

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12134

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First Mildred	Middle	Last Adams	2a. DATE OF DEATH Month Day Year August 9, 1968	2b. HOUR IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 8, 1882	6. AGE (In years last birthday) 85	7. BIRTHPLACE (State or foreign country) Baltimore, Md.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fahrney- Keedy Mem. Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housekeeper	12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Clearspring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME First James	Middle Coleman	Last Adams	15. MOTHER'S MAIDEN NAME First Henreitta	Middle Eddy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO. 220-46-7629	17. INFORMANT Fahrney- Keedy Home Records, Rfd. 1	Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension & cardio Vasocodar Vasocere</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> <i>4120</i>				DUE TO, OR AS A CONSEQUENCE OF		
(b) <i>443X</i>				DUE TO, OR AS A CONSEQUENCE OF		
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nameify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 5, 1968</i> , to <i>Aug 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug 5, 1968</i> , and that an (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>G. W. LeVan M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Aug. 10, 1968</i>	
22d. PHYSICIAN'S NAME (Type) G. W. LeVan		22e. ADDRESS Boonsboro Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-12-68	23c. NAME OF CEMETERY OR CREMATORIAL St. Pauls Cemetery	23d. LOCATION (City or Town) Clearspring, Wash. Co., Md.	(County) (State)	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE AUG 13 1968	25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12125

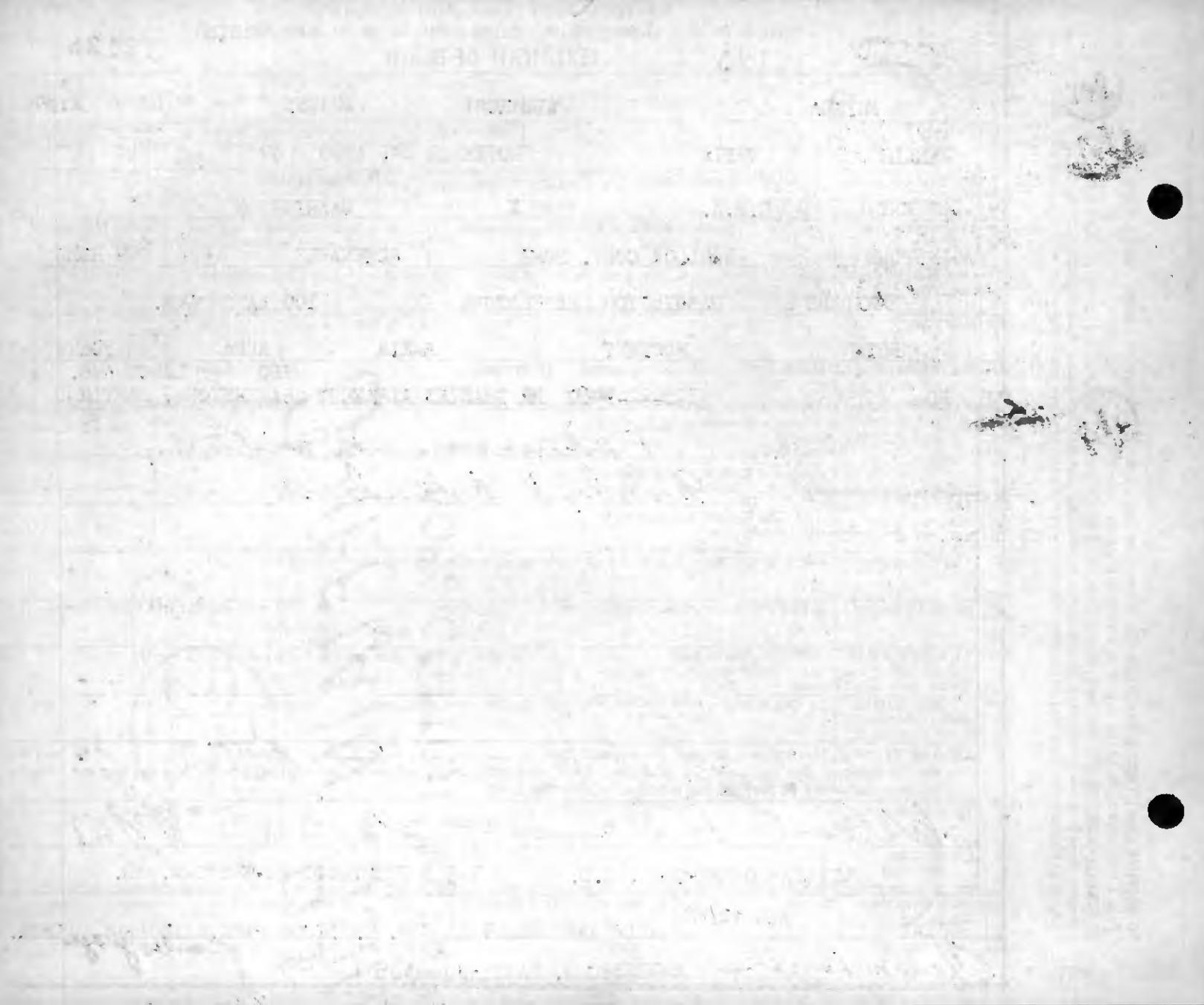
CERTIFICATE OF DEATH

12135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First FRIEDA	Middle	Lost ALBRECHT	2a. DATE OF DEATH Month AUGUST Day 8 Year 68	2b. HOUR 2:30 a.m.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH NOVEMBER 24, 1898		6. AGE (In years last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) GERMANY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON			
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GARLOCK CONV. HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 100 LARCH AVE.		
14. FATHER'S NAME First PETER	Middle RUCKERT	15. MOTHER'S MAIDEN NAME First MARIA	Middle ANNA	Lost FOERG		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 193-22-9460	17. INFORMANT MR. CHARLES ALBRECHT	100 Address LARCH AVE.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART 1. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) Parkinsonism with Dementia, etc.						
342 X						
DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
350X						
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on July 13th 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.						
22b. SIGNATURE William O. Rexrode						
22d. PHYSICIAN'S NAME (Type)	22e. DEGREE WILLIAM O. REXRODE, M.D.		ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22f. DATE SIGNED 8/8/68
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUG 12/68	23c. NAME OF CEMETERY OR CREMATORIAL ALLEGHENY MEMORIAL CEM.	23d. LOCATION (City or Town) ALLISON PARK ALLEGHENY PENNA.	(County)	(State)	
24. FUNERAL DIRECTOR Clarkson Langer	ADDRESS HAGERSTOWN, MARYLAND	25a. REC'D BY REGISTRAR AUG 12 1968	25b. REC'D BY CLERK 12/13/68			



MARYLAND STATE DEPARTMENT OF HEALTH

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Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Minnie	Middle Margaret	Last Babington	2a. DATE OF DEATH Month August	Day 30	Year 1968	2b. HOUR 7:41			
3. SEX female	4. RACE white	5. DATE OF BIRTH Jan. 18, 1894			6. AGE (In years last birthday) 74 yrs.					
7a. BIRTHPLACE (State or foreign country) Fred. Co. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	MIN.
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 149 W. Franklin St.	Md.					
14. FATHER'S NAME Simon P. Eccard	First	Middle	Last	15. MOTHER'S MAIDEN NAME Effie	Middle	Last Shuff	Address			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 212-03-3809			17. INFORMANT G.C. Babington, 149 W. Franklin, Hagerstown	Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							4109 Gastroenteric Heart Disease unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							Diseased 07/10/2017			
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State					
22a. I certify that (I) (this hospital) attended the deceased from 8/28, 1968, to 8/30, 1968, that (I) (we) last saw the deceased alive on 8/28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. DATE SIGNED 8/30/68				
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 301 W. Franklin, Hagerstown, Md.	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR, <input type="checkbox"/> STAFF PHYS.							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Sept. 2, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Salem U. Methodist	23d. LOCATION (City or Town) Wolfsville, Fred. Co. Md.	(County)	(State)					
24. FUNERAL DIRECTOR T. F. Bittle	ADDRESS Paul F. Bittle, Myersville, Md.			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles George					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Paul</i>	Middle <i>Franklin</i>	Last <i>Bailey</i>	2a. DATE OF DEATH Month <i>August</i>	Day <i>8</i>	Year <i>1968</i>	2b. HOUR <i>10:25 P.M.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>February 27, 1920</i>		6. AGE (In years last birthday) <i>48</i>	7. IF UNDER 1 YEAR MONTHS <i>0</i>		8. IF UNDER 24 HRS. HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Hagerstown, Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Washington</i>			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>fork lift operator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Druck Mfg.</i>		
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Maryland</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>224 Norway Ave.</i>			
14. FATHER'S NAME First <i>Robert</i>	Middle <i>A</i>	Last <i>Bailey</i>	15. MOTHER'S MAIDEN NAME First <i>Sarah</i>	Middle <i>Zink</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give no. or date of service) <i>219-05-2125</i>	17. INFORMANT <i>Mrs. Norma Bailey</i>	Address <i>224 Norway Ave. Hagerstown, Md.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 months</i>		
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Of Lung</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Cardiac Failure</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)							
163X MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <i>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. <i>19</i> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) <i>at work</i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>at work</i>	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 19 68</i> , to <i>Aug. 8, 19 68</i> , that (I) (we) last saw the deceased alive on <i>Aug. 7, 19 68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) view the body after death.							
22b. SIGNATURE <i>D. E. W. Ditte, Jr.</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Aug. 9, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>Dr. E. W. Ditte, Jr.</i>		22e. ADDRESS <i>215 W. Washington St., Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8/11/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rest Haven Cemetery</i>	23d. LOCATION (City or Town) <i>Hagerstown-Washington Md.</i>		(County) <i>Hagerstown</i>	(State) <i>MD</i>
24. FUNERAL DIRECTOR <i>W. C. Hox</i>		ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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CERTIFICATE OF DEATH

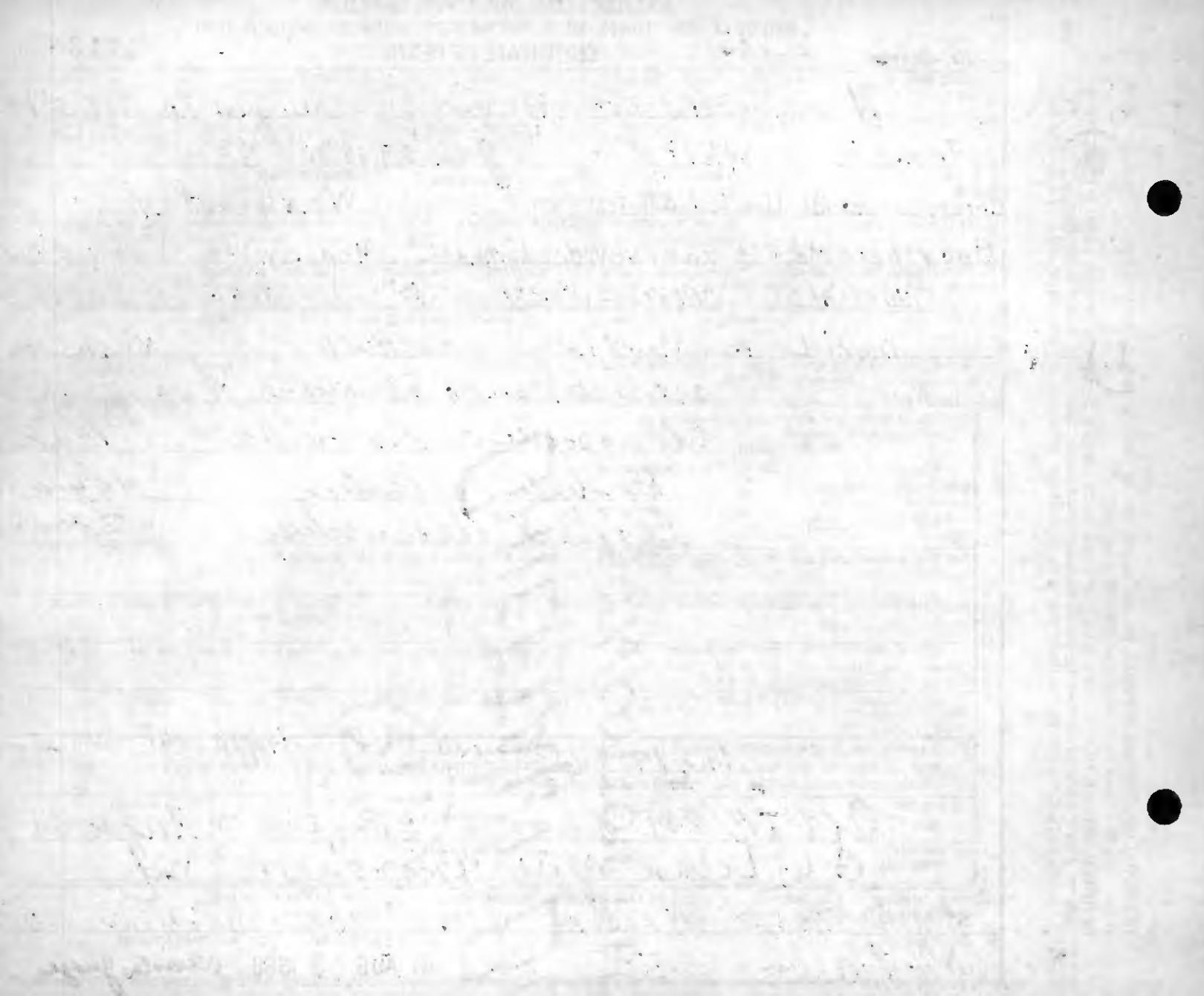
12138

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

executed within 24 hours after death.
Page 4 may be returned by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Nina	Middle BEYINGTON	Last Bear	2a. DATE OF DEATH Month August	Day 20	Year 1968	2b. HOUR 5 ²⁹ M
3. SEX Female	4. RACE White	5. DATE OF BIRTH Jan. 29, 1893		6. AGE (in years lost birthday) 73 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS
7a. BIRTHPLACE (State or foreign country) Covers Corner, Md	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Boonsboro, Md	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physician's Name Hathaway, Hecdyne, Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13c. CITY OR TOWN CARROLL	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER RIDGEVILLE				
14. FATHER'S NAME David	First W	Middle Martin	Last RACHAEL	15. MOTHER'S MAIDEN NAME Nusbaum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 218-12-6069	17. INFORMANT Thelma Shoemaker	Address Yellow Springs, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Internoscoptic cardio embolus</i> APPROXIMATE INTERVAL 2509 BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> <i>Diabetes mellitus</i> 10 yrs							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Haemorrhage</i> 10 yrs							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral Haemorrhage</i> 3 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
260X							
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19</u> , 1968, to <u>Aug 20</u> , 1968, that (I) (we) last saw the deceased alive on <u>Aug 19</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. W. LeVan M.D.	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Aug 20, 68			
22d. PHYSICIAN'S NAME (Type) G. W. LeVan M.D.	22e. ADDRESS Boonsboro, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE AUG 23 1968	23c. NAME OF CEMETERY OR CREMATORIAL LOCUST GROVE	23d. LOCATION (City or Town) LIBERTYTOWN RURAL MD	(County)	(State)		
24. FUNERAL DIRECTOR Dr. Hertzler & Son, Libertytown, Md.	ADDRESS	25a. REC'D BY REGISTRAR Charles J. George	25b. REGISTRAR'S SIGNATURE Charles J. George	DATE AUG 22 1968			



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												18129	139	
1. DECEASED NAME (Type or Print)			First CHARLES	Middle GEORGE	Last BITTORF	20. DATE KNOWN OF ESTI. DEATH MATED			Month Aug.	Day 22	Year 1968	24 HOUR 1:30 A.M.		
3 SEX <input checked="" type="checkbox"/> M	4 RACE WHITE	5 DATE OF BIRTH MAR 1, 1890	6 AGE in years 78 YRS	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 COUNTY OF DEATH WASHINGTON COUNTY	21. DATE PRONONCED DEAD Month Aug. Day 22			Year 1968	25 HOUR 1:30 A.M.			
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TELEGRAPH OPER.			12b. KIND OF BUSINESS OR INDUSTRY RAILROAD					
10 CITY OR TOWN OF DEATH HAGERSTOWN, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TELEGRAPH OPER.			13a. CITY OR TOWN WASH. CO. HAGERSTOWN			13b. STREET AND NUMBER 807 WASHINGTON AVE.				
13a. USUAL RESIDENCE (Where deceased resided, if institution or residence before admission) MARYLAND		13c. CITY OR TOWN WASH. CO. HAGERSTOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 807 WASHINGTON AVE.							
14. FATHER'S NAME First GEORGE			Middle	Last BITTORF	15. MOTHER'S MAIDEN NAME CHRISTINA			16. ADDRESS 807 WASH. AVE. HAGERSTOWN, MD			17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hours			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> unknown)			16b. SOCIAL SECURITY NO. 705-10-8771			17. INFORMANT MRS. BEATRICE BITTORF								
18. CAUSE OF DEATH (Enter on a line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage in Rt. Basal Ganglia & Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hemisphere, With Destruction Of</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <u>Parietal & Temporal Lobes.</u>			18. CAUSE OF DEATH (Enter on a line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage in Rt. Basal Ganglia & Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hemisphere, With Destruction Of</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <u>Parietal & Temporal Lobes.</u>			18. CAUSE OF DEATH (Enter on a line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage in Rt. Basal Ganglia & Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hemisphere, With Destruction Of</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <u>Parietal & Temporal Lobes.</u>			18. CAUSE OF DEATH (Enter on a line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage in Rt. Basal Ganglia & Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hemisphere, With Destruction Of</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <u>Parietal & Temporal Lobes.</u>			18. CAUSE OF DEATH (Enter on a line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage in Rt. Basal Ganglia & Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hemisphere, With Destruction Of</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <u>Parietal & Temporal Lobes.</u>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR <u>4:30 P.M.</u> Aug. 21, 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) Head on collision with rear of car in front of him.								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) W. Wash. St., & Elgin Blvd.			21f. LOCATION Street or R.F.D. No. City of Town Hagerstown, Washington, Md.			21g. County			21h. State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22b. CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
ACTUAL SIGNATURE <u>E. W. Ditte, Jr.</u>						22c. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						22d. DATE SIGNED Aug. 23, 1968		
EXAMINER'S NAME (Type) Dr. E. W. Ditte, Jr.			22e. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22f. ADDRESS 215 W. Washington St., Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE AUGUST 24, 1968			23c. NAME OF CEMETERY OR CREMATORIUM REST HAVEN CEM.			23d. LOCATION (City or Town) HAGERSTOWN WASH CO., MD			(County) (State)		
24. FUNERAL DIRECTOR W. T. Harcourt			25a. ADDRESS Hagerstown, Md.			25b. REC'D BY REGISTRAR AUG 26 1968			25c. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION

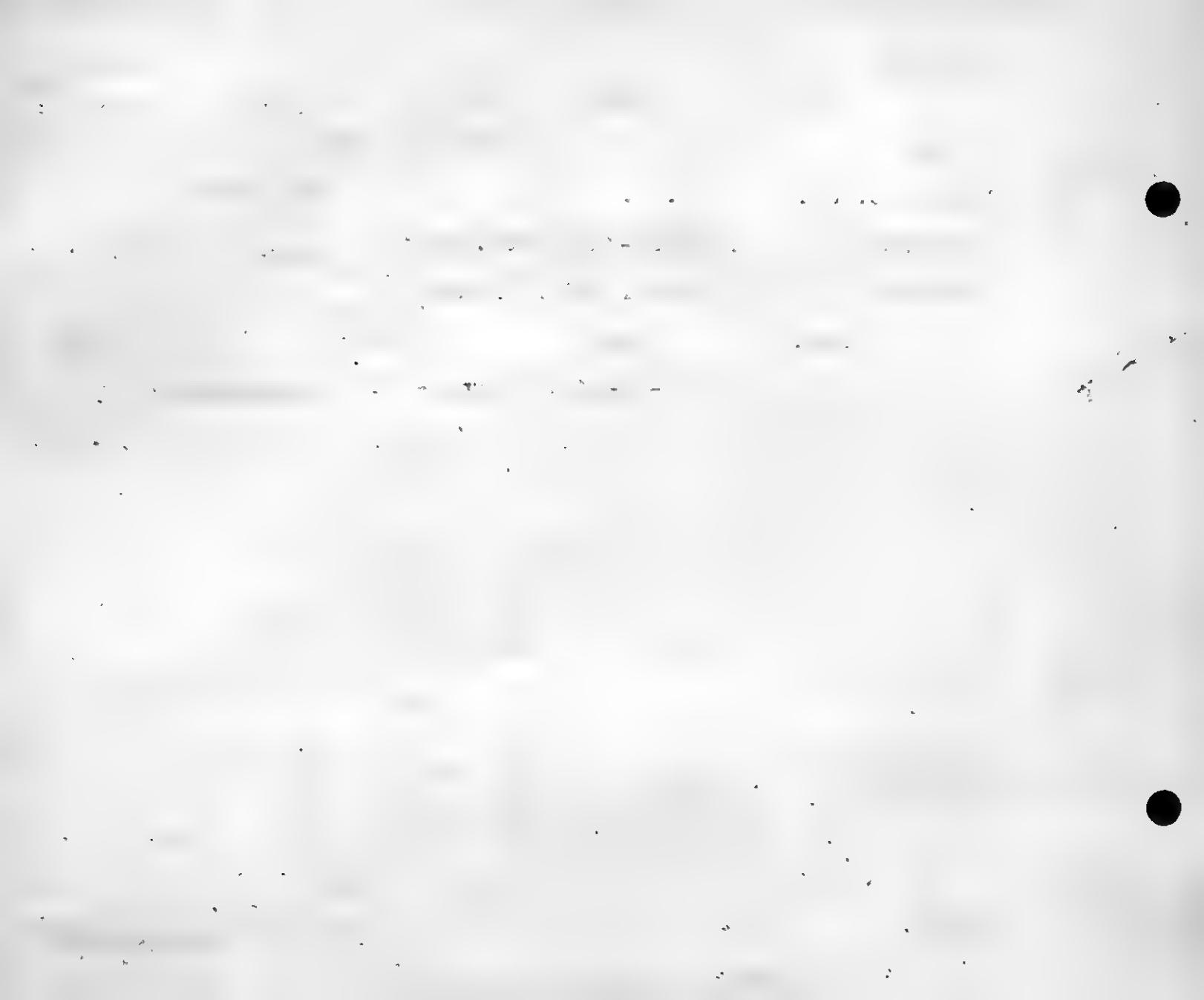
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Charles Middle Nicholas Lost Bohn				2a DATE OF DEATH Month August Day 9, Year 1968	2b HPM 10:30		
3. SEX Male	4 RACE White	5 DATE OF BIRTH March 19, 1880	6 AGE (In years last birthday) 89	7f UNDER 1 YEAR MONTHS DAYS	7f UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign) Carroll Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. COUNTY OF DEATH Washington		10. CITY OR TOWN OF DEATH Boonsboro					
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital Fahrney-Keedy Mem. Home		12a. USUAL OCCUPATION (Kind of work done most of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY HARDWARE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13c. CITY OR TOWN Carroll Union Bridges		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Reuben Middle Bohn Lost		15. MOTHER'S MAIDEN NAME Effie ELFIE		16. STREET AND NUMBER MAIN ST.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 216-03-6417		17. INFORMANT Fahrney-Keedy Home Records Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instantly DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 9, 1968</i> , to <i>Aug 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>G. White Van M.D.</i>		22c. DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22d. DATE SIGNED <i>Aug 10, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>G. White Van M.D.</i>		22e. ADDRESS <i>Boonsboro, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE 8/13/68	23c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK		23d. LOCATION (City or Town) (County) (State) <i>NEW WINDSOR Carroll MD</i>		
24. FUNERAL DIRECTOR <i>DD Hartzer & Sons Union Bridge</i>		25a. ADDRESS <i>Boonsboro, Md.</i>		25b. REC'D BY REGISTRAR DATE <i>AUG 14 1968</i>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

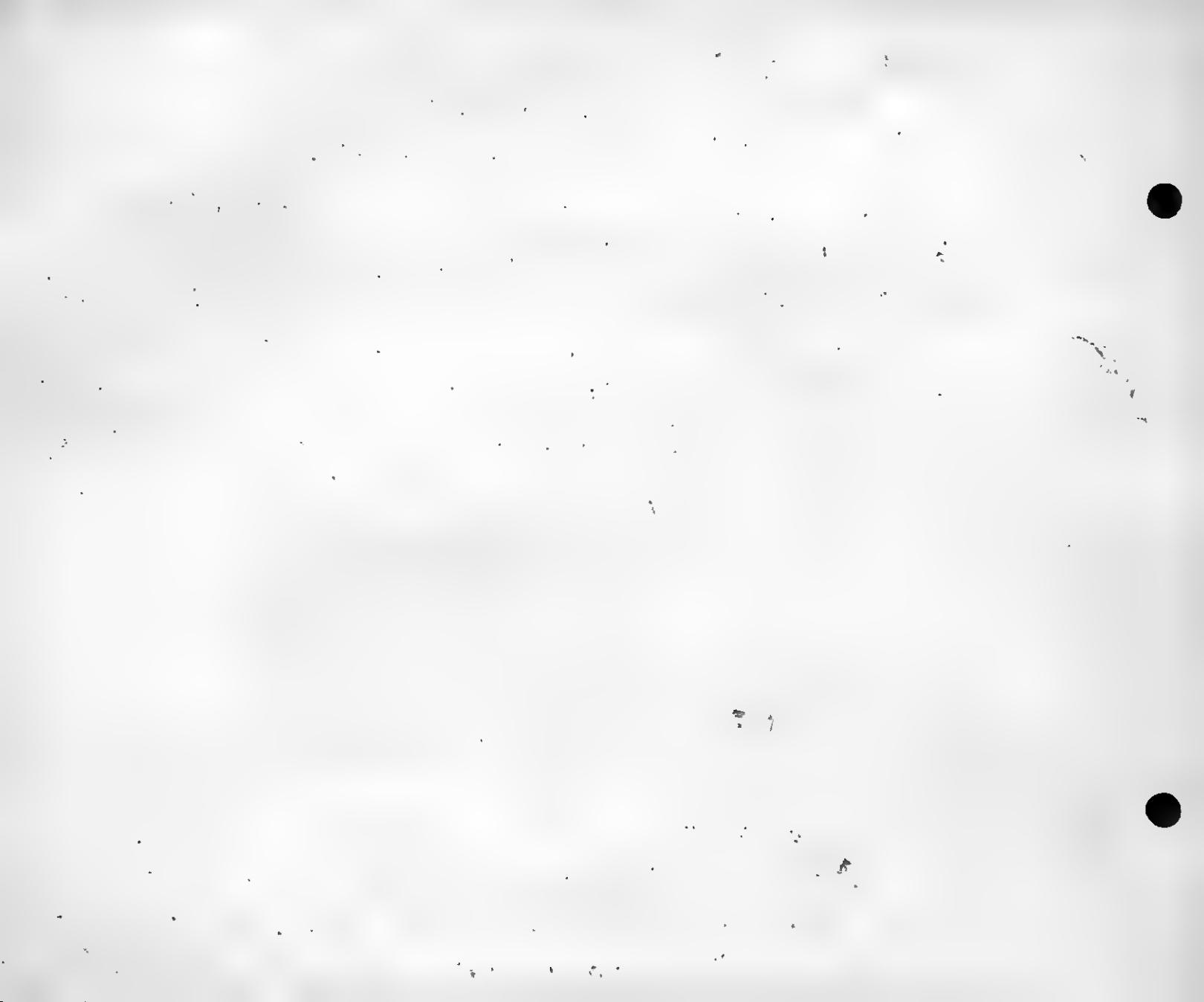
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED NAME (Type or print)	First <i>Sarah</i>	Middle <i>Ann</i>	Last <i>Brewer</i>	2a. DATE OF DEATH Month <i>8</i>	2b. HOUR <i>9:10 P.M.</i>		
3. SEX <i>F</i>	4 RACE <i>W</i>	5. DATE OF BIRTH <i>3-22-1883</i>		6. AGE (in years lost birthday) <i>85</i>	7. IF UNDER 1 YEAR MONTHS <i>85</i>	8. IF UNDER 24 HRS DAYS <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Washington</i>		
10. CITY OR TOWN OF DEATH <i>Williamsport</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Homewood Church Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House wife</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY (L.M.S.P.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>912 Hamilton Blvd</i>		
14. FATHER'S NAME First <i>John</i>	Middle <i>J.</i>	Last <i>Hamilton</i>	15. MOTHER'S MAIDEN NAME First <i>Sarah</i>	Middle <i>Ann</i>	Last <i>Ralston</i>	16b. SOCIAL SECURITY NO <i>217-42-7696</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES Yes, no, or unknown <i>NO</i>	16c. INFORMANT Address <i>Markel Woogner 2750 Va Ave Wmsport</i>		17. BETWEEN ONSET AND DEATH <i>6 days</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension C/T Dis</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>10 years</i>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <i>137 W. Washington</i>	City or Town <i>Hagerstown, Md</i>	County <i>Washington</i>	State <i>Md</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 30, 1968</i> to <i>8-6-1968</i> , that (I) (we) last saw the deceased alive on <i>8-6-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert P. Leonard</i>		DEGREE <i>MD</i>	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>8-6-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Robert P. Corratt</i>		22e. ADDRESS <i>137 W. Washington</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>Aug 9-1968</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) <i>Hagerstown</i>	(County) <i>Washington</i>	(State) <i>Md</i>
24. FUNERAL DIRECTOR <i>Hagerstown Inc.</i>		ADDRESS <i>Andrew K. Coffman Funeral Home, Inc.</i>	25a. RCD BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>AUG 9 1968</i>	



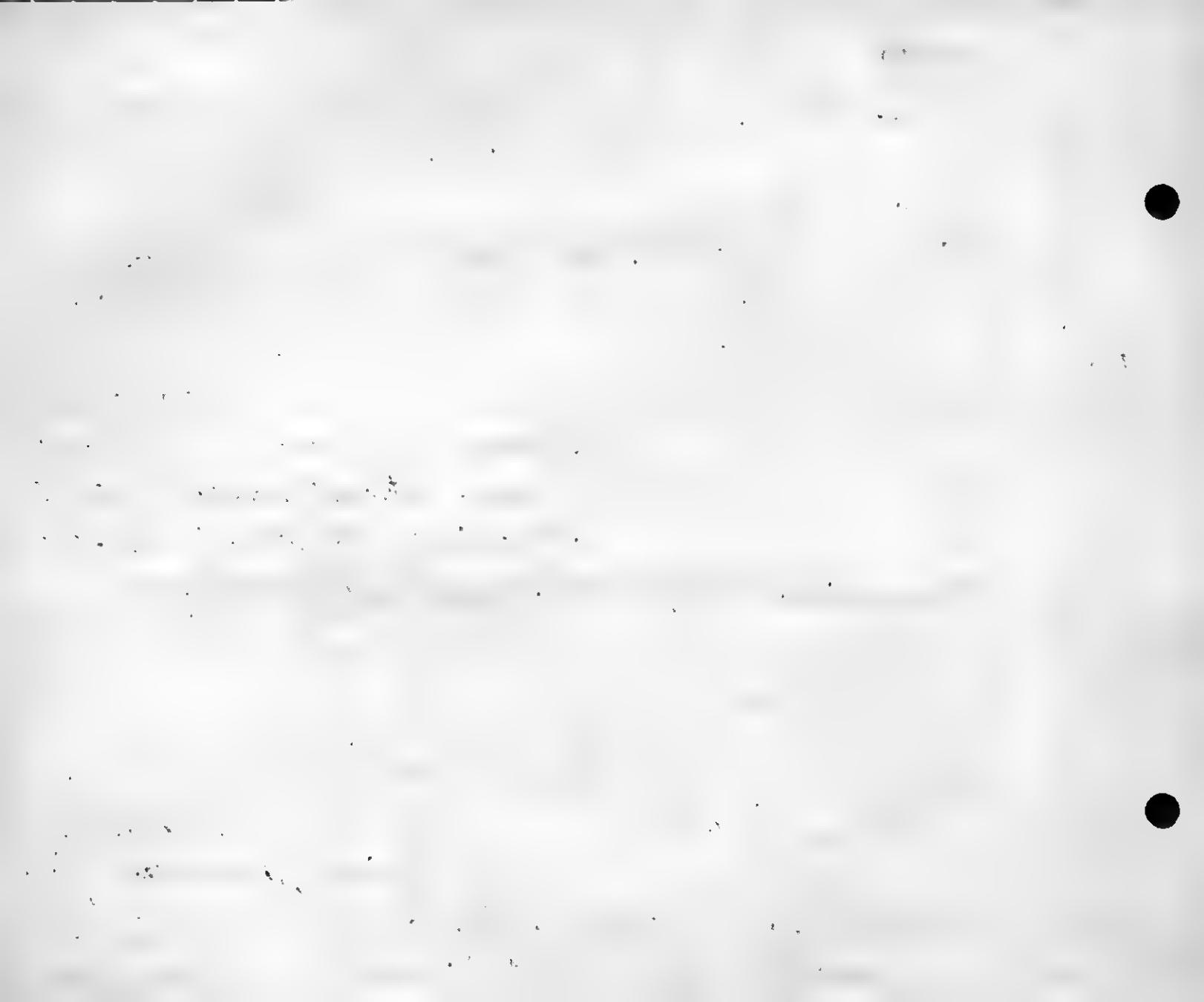
CERTIFICATE OF DEATH

142

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. ~~Both pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.~~

1 DECEASED NAME (Type or print)	First <i>Sarah F</i>	Middle	Last <i>Buckley</i>	2a DATE OF DEATH Month <i>Aug</i> Day <i>14</i> Year <i>1968</i>	2b HOUR <i>11:00 P.M.</i>
3 SEX female	4. RACE white	5 DATE OF BIRTH Jan 22, 1888	6 AGE (In years last birthday) <i>80</i> YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a BIRTHPLACE (State or foreign country) Penns	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10 CITY OR TOWN OF DEATH HAGERSTOWN	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cashier	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md	13b. COUNTY Pro George's	13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 9 G Laurel Hill Road	
14. FATHER'S NAME Barney S French	First	Middle	Last	15. MOTHER'S MAIDEN NAME Fannie E. Moreland	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO 578 093 811	17. INFORMANT Barbara E Buckley	Address Greenbelt, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 mned</i> <i>Coronary occlusion</i>		
(b) <i>Coronary atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>years</i>			<i>years</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>healed duodenal ulcer, pulmonary embolism, nephrosclerosis</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <i>4-21-1968</i> to <i>8-14-1968</i> , that (I) (we) last saw the deceased alive on <i>8-13-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Edwin G Riley</i>		DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>8-15-68</i>
22d. PHYSICIAN'S NAME (Type) <i>Edwin G Riley</i>		22e. ADDRESS <i>1500 Penns, Hagerstown, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 19, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Middletown Association	23d. LOCATION (City or Town) Middletown	(County) Dauphin (State) Pa.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE AUG 19 1968	25b. REGISTRAR'S SIGNATURE <i>Charles George</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12133

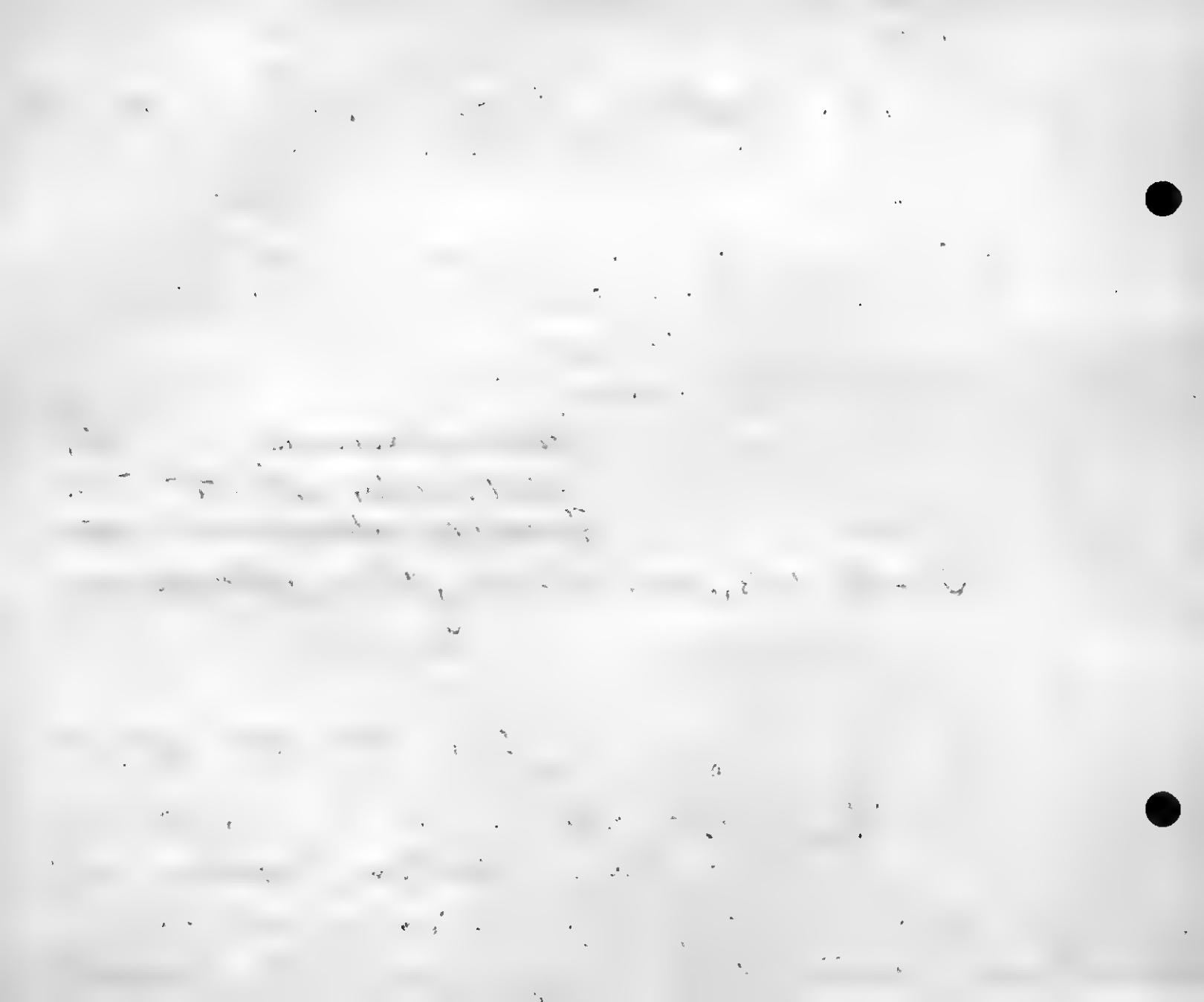
CERTIFICATE OF DEATH

12143

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 DECEASED NAME (Type or print)	First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR 11:55 P.M.
Tillie Josephine Burgus					
3 SEX FEMALE	4. RACE CAUCASIAN	5 DATE OF BIRTH MAY 10 1896	6. AGE (in years last birthday) 72 yrs	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) KANSAS	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERS TOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY
13a. LEGAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE MARYLAND	13b. COUNTY PRINCE GEORGES	13c CITY OR TOWN LANHAM	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5520 BELVA, ST.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last
				KIRKEMINDE	UNKNOWN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) UNKNOWN	17 INFORMANT PAUL F. BURGUS	Address SAME AS #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobular pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5d DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, (which gave rise to immediate cause (a), stating the underlying cause lost) (b) <i>Cerebral vascular infarct</i> 2 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i> years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Two old M1's, renal calculus, chronic pyelonephritis</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>6-19</u> , 1967, to <u>8-7</u> , 1968, that (I) (we) last saw the deceased alive on <u>8-7</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <i>Edwin G. Riley, M.D.</i>	DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 8-8-68			
22d. PHYSICIAN'S NAME (Type) EDWIN G. RILEY, M.D.	22e. ADDRESS 1500 Penna, Hagerstown, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8-9-1968	23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEM.	23d. LOCATION (City or Town) SUITLAND	(County) MARYLAND	(State)
24. FUNERAL DIRECTOR W.W. CHAMBERS	ADDRESS Co. RIVERDALE, MD	25a. REC'D BY REGISTRAR DATE AUG 13 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12183 144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARY MAGDELENE STRITE-BUSSARD				August 27 1968	3 P M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Female	White	May 5 1888		80 yrs	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH	
Maryland	USA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Washington	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Hagerstown	Avalon Manor			Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	12b. KIND OF BUSINESS OR INDUSTRY
Maryland	Washington	Hagerstown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	402 Summit Ave	Own Home
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
John H. Heil				Clara Rebecca Gross	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO (If yes give year or dates of service)	17. INFORMANT	Address		
No	--	Wm. H. Bussard	Mr. Heyser Bussard 2908 Russell Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY.	Alexandria Va. 22305				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction				About 1 hour
4107 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease				15 years?
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on	10-9-1968	to	6-28-1968	, that (I) (we) lost and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE	John H. Hornbaker, M.D.				22c. DATE SIGNED 8-28-68
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		154 West Washington St., Hagerstown, Md. 21740		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City or Town) (County) (State)		
Burial	9/20/68	Rose Hill Cemetery	Hagerstown Wash Co Md.		
24. FUNERAL DIRECTOR	Hagerstown Md.	ADDRESS	25a. REGISTRATION NUMBER	25b. REGISTRAR'S SIGNATURE	
Andrew K. Coffman Funeral Home Inc			AUG 30 1968	Charles Judge	

FOR STATE
HEALTH DEPT.

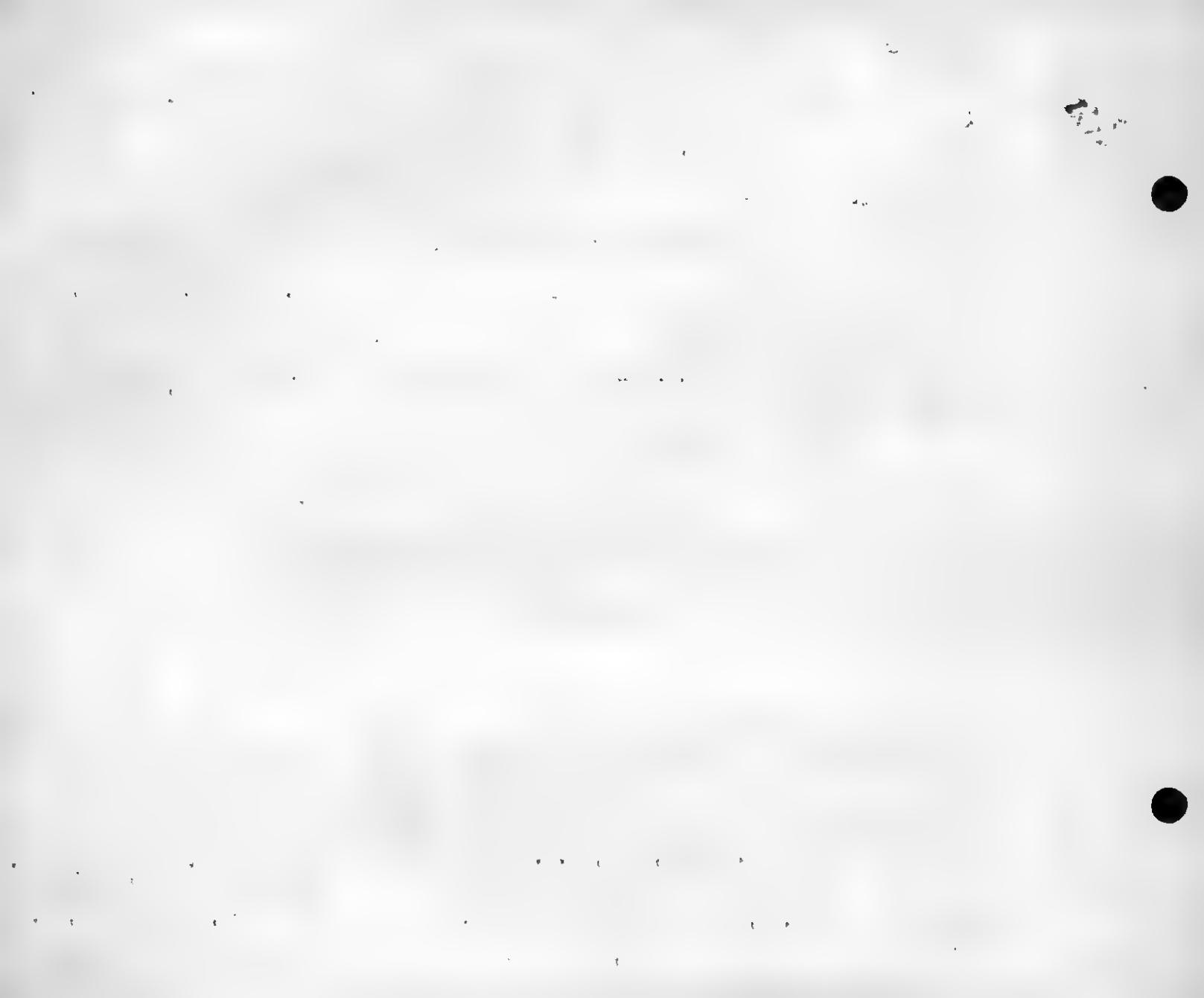


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
1013 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First Earl	Middle Leroy	Last Byers	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year Aug. 15 1968	2b. HOUR 9:45 AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 30, 1910	6. AGE (In years last birthday) 58 yrs	7. IF UNDER 1 YEAR 4 MONTHS	8. IF UNDER 24 HRS 15 DAYS	9. IF HOURS 0 HOURS	10. DATE OF ESTI. DEATH MATED <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Memory		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) Maryland		13c. CITY OR TOWN Washington Williamsport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8 S. Conococheague St.		
14. FATHER'S NAME First John		Middle Harvey	Last Byers	15. MOTHER'S MAIDEN NAME First Bessie		Middle Viola	Last Sterling	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIA. SECURITY NO (If yes give war or dates of service) 214-10-3982		17. INFORMANT Miss Janice Byers		ADDRESS Williamsport, Maryland		
18. CAUSE OF DEATH (Enter only one cause per Part 1. DEATH WAS CAUSED BY 4109		IMMEDIATE CAUSE (a) Thromboc. Occlusio. st. DUE TO, OR AS A CONSEQUENCE OF Coronary Artery				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 46-6 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) DUE TO, OR AS A CONSEQUENCE OF Coronary Occlusion, sever. 15 yrs		(c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
22b. DATE SIGNED 8-16-68								
ACTUAL SIGNATURE <i>Edward W. Ditto, III, M.D.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial								
23b. DATE Aug. 18, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		23d. LOCATION (City or Town) Williamsport, Washington, Md.		(County) (State)		
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport, Maryland.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

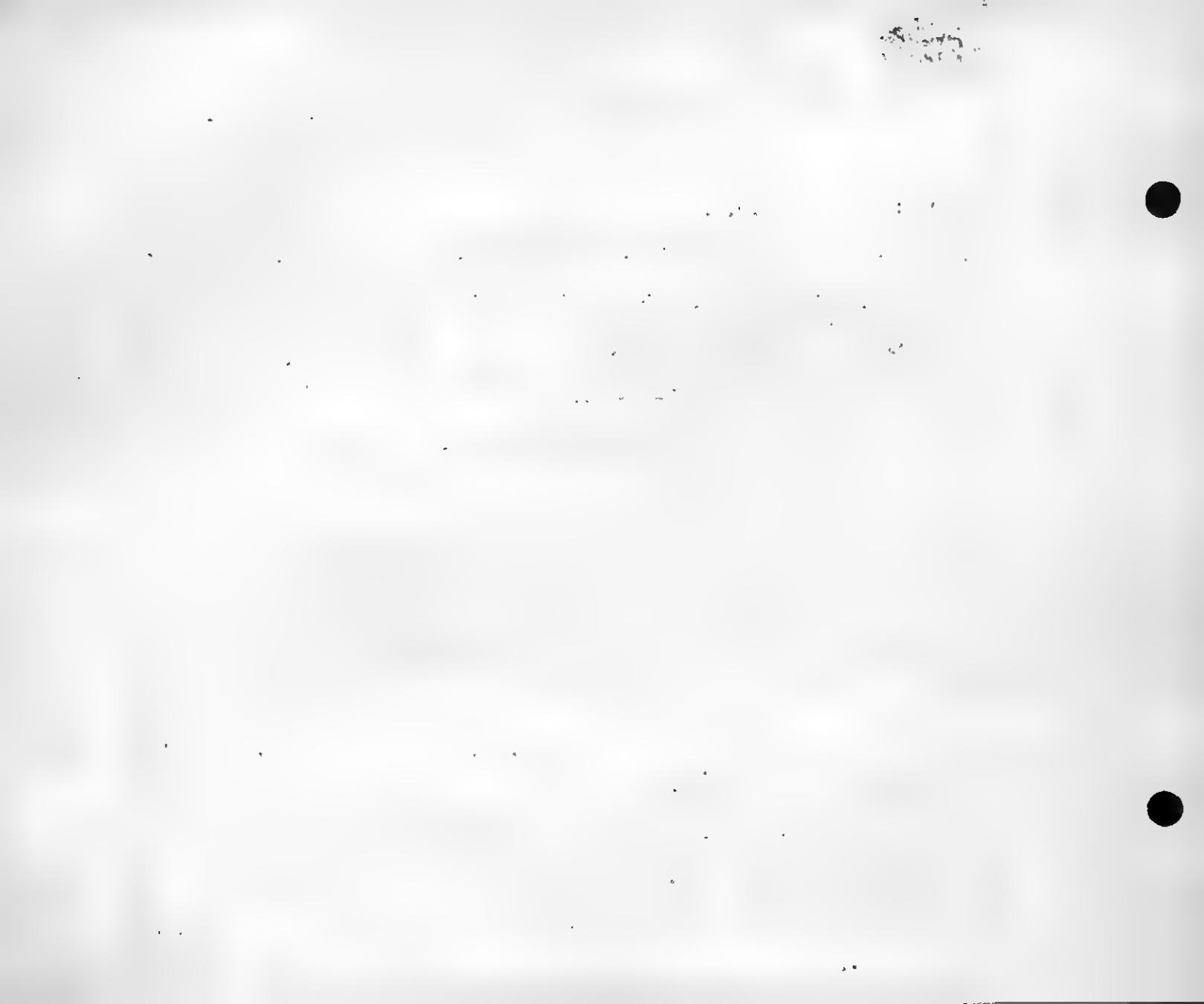
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. **Sec. 1** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 6:20 p.m.
CATHERINE CONNER BYRON			AUGUST 13 1968				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH NOVEMBER 18, 1893		6. AGE (In years last birthday) 74 yrs	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AVALON MANOR NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY AMERICAN CANCER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY (W.M.T.) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME ASHBY		First MIDDLE Last PATRICK CONNER		15. MOTHER'S MAIDEN NAME First ADDIE		16. STREET AND NUMBER 1334 POTOMAC AVE.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. NO 220-18-1606		17. INFORMANT EDWARD J. BYRON		18. ADDRESS POTOMAC AVE. HAGERSTOWN, MARYLAND	
<p>18. CAUSE OF DEATH (Enter on a line for (a), (b) and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the breast with multiple metastases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Indefinite</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c),</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(b)</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>							
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>11</p>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) <input checked="" type="checkbox"/> Kneisley attended the deceased from Sept. 18, 1964, to Aug. 13, 1968, that (I) <input type="checkbox"/> last saw the deceased alive on Aug. 13, 1968, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did <input type="checkbox"/> not view the body after death.							
22b. SIGNATURE <i>B.B. Kneisley</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 8/14/68	
22d. PHYSICIAN'S NAME (Type) B.B. KNEISLEY, M.D.		22e. ADDRESS 145 W. WASHINGTON ST., HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8/16/68		23c. NAME OF CEMETERY OR CREMATORIAL xxx ROSE HILL CEMETERY HAGERSTOWN		23d. LOCATION (City or Town) WASHINGTON MD.	
24. FUNERAL DIRECTOR		ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D. BY REGISTRAR DATE AUG 19 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please sign on 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH
Hazel Bernice Cairns		8	2b. Month: Day: Year	2b. 26 HOUR 29 68/10:45 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) 76 yrs	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Female	White	4-9-1892	76	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	
Cartersville, Georgia	U.S.A.		Washington	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red)	12b. KIND OF BUSINESS OR INDUSTRY	
Boonsboro	Fahmey-ReedylHome	Proxy Office	LAW	
13a. USUAL RESIDENCE (Where deceased lived/ if institution: Residence before admission) STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MD	CARROLL NEW WINDSOR		CHURCH ST.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME
CHARLES		SELL		ANNA
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address	
No	NONE	ROBERT CAIRNS	NEW WINDSOR MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage				30 days
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardio vascular				10 years
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus				10 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 20</u> , 1968, to <u>Aug 27</u> , 1968, that (I) (we) last saw the deceased alive on <u>Aug 27</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE	22c. DEGREE		ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County) (State)
BURIAL	AUG 27-1968	PIPE CREEK	NEW WINDSOR RURAL MD	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
DD Hartsler & Sons	New Windsor	DATE AUG 28 1968	Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15135 CERTIFICATE OF DEATH

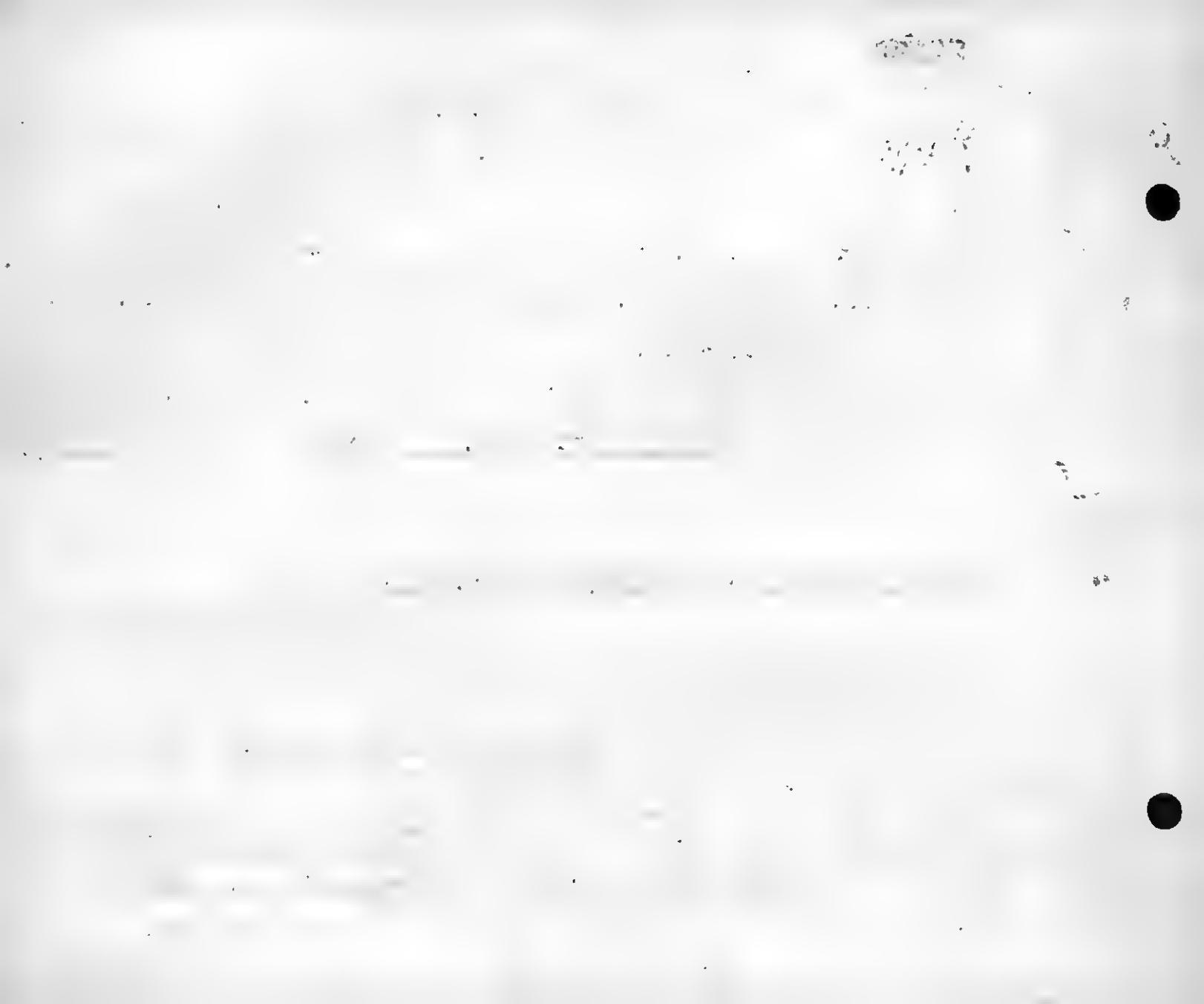
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Lily	Middle Cromwell	Last Chenoweth	2a. DATE OF DEATH Month August	Day 18	Year 1968	2b. HOUR 6:00 A.M.
3. SEX female	4. RACE white	5. DATE OF BIRTH 2-11-1882		6. AGE (In years last birthday) 88	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital			12a. USUAL OCCUPATION (Kind of work done during most working life, even if retired) Sever			12b. KIND OF BUSINESS OR INDUSTRY Chemical Mfg.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1100 Virginia, Ave.			
14. FATHER'S NAME James W. Chenoweth	15. MOTHER'S MAIDEN NAME Emma McCalele						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO (If you give war or dates of service) 214-09-4893	17. INFORMANT Mrs. Virginia S. Clopper	Address Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonitis, chronic, R.I.L.</i> 517 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arterio sclerosis, arteriosclerotic heart disease.</i>							
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>4/15</i> , 1968, to <i>8/18</i> , 1968, that (I) (we) last saw the deceased alive on <i>8/17</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George Jennings</i>	DEGREE ATTENDING PHYS.	22c. DATE SIGNED <i>8/19/68</i>	MED. DIRECTOR	STAFF PHYS.			
22d. PHYSICIAN NAME (Type) <i>George Jennings</i>	22e. ADDRESS 318 N. Potomac St. Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-20-68	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Hagerstown, Md.	(County)	(State)		
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.	ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 23 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



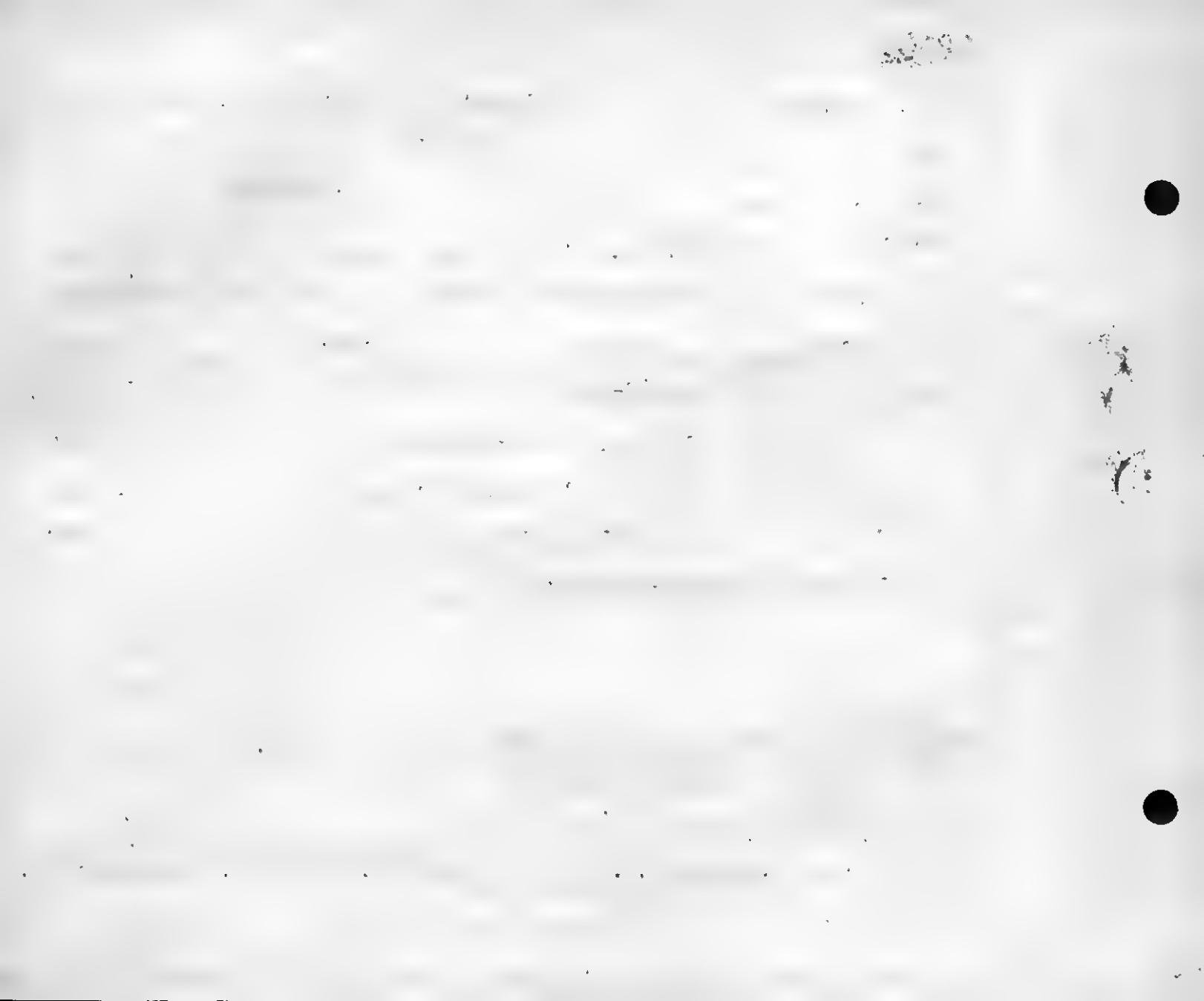
CERTIFICATE OF DEATH

149

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and date this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

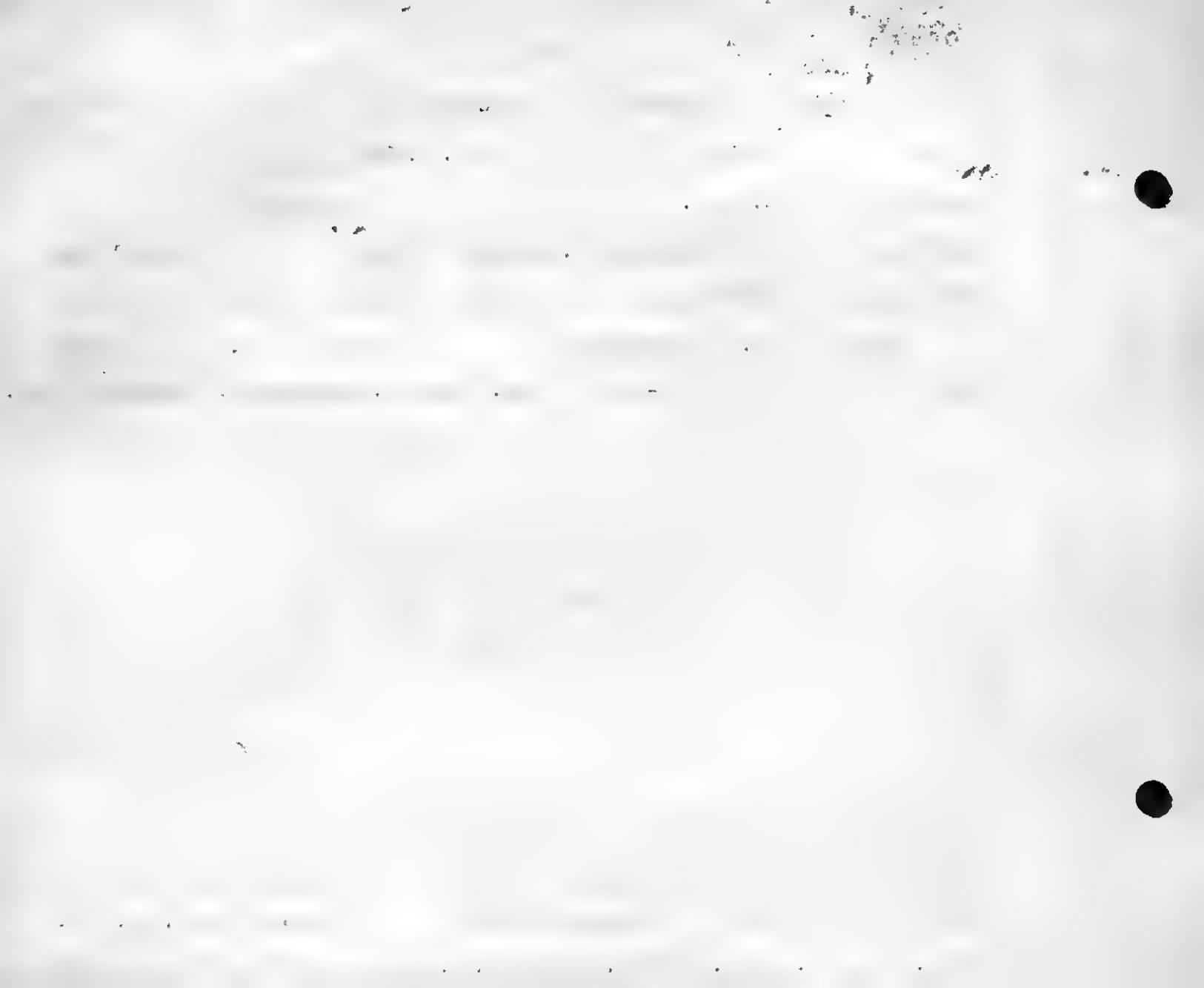
1. DECEASED NAME (Type or print)	First Benjamin	Middle Chepenik	Last Chepenik	2a. DATE OF DEATH Month Day Year August 16 1968	2b. HOUR 4:37 M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 7/14/07		6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF OVER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Connecticut	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH WASHINGTON		10. CITY OR TOWN OF DEATH HAGERSTOWN		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Produce			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER Apt. T2 1927 East West Highway	14. FATHER'S NAME First Nathan		
15. MOTHER'S MAIDEN NAME First Chepenik		16. SOCIAL SECURITY NO. 264-40-2125		17. INFORMANT Eva Chepenik	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF last. (c) Diabetes mellitus		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bilateral amputation above knees							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from June 22, 1967 , to Aug. 16, 1968 , that (I) (we) lost saw the deceased alive on August 16 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Chong Choon Han</i>	DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 8/16/68			
22d. PHYSICIAN'S NAME (Type) Chong Choon Han, M.D.	22e. ADDRESS Western Maryland State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.						
23a. BUR. A. CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 18, 1968	23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Garden	23d. LOCATION (City or Town) Falls Church, Virginia	(County)	(State)		
24. FUNERAL DIRECTOR Donald M. Stein	ADDRESS 232 Carroll	25a. REC'D BY REGISTRAR AUG 20 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
Hebrew Memorial Funeral Home St. N.W. Wash. D.C.				DATE			



CERTIFICATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Daniel	Middle Harold	Last Chrissinger	2a. DATE OF DEATH Month August	Day 31	Year 1968	2b. HOUR 9:45 A M
3. SEX Male	4 RACE White	5. DATE OF BIRTH Oct. 8, 1905		6. AGE (In years last birthday) 62	IF UNDER 1 YEAR MONTHS 10	IF UNDER 24 HRS. DAYS 23	IF UNDER 24 HRS. HOURS MIN. 00
7a. BIRTHPLACE (State or foreign country) Boonsboro, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington			
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Labor		12b. KIND OF BUSINESS OR INDUSTRY General Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Keedysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rfd. 1			
14. FATHER'S NAME First Elmer	Middle N.	Last Chrissinger	15. MOTHER'S MAIDEN NAME First Flora	Middle V.	Last Moser		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 224-10-8717	17. INFORMANT Mrs. Goldie M. Chrissinger, Keedysville, Rfd.	Address 1, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ARTERIOSCLEROTIC COR. ART. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) MASSIVE LEFT PLEURAL EFFUSION WITH ATELECTASIS							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. _____	City or Town _____	County _____	State _____		
22a. I certify that (I) (this hospital) attended the deceased from 8/14 , 1968, to 8/31 , 1968, that (I) (we) last saw the deceased alive on 8/31 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Seaman</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 9/2/68		
22d. PHYSICIAN'S NAME (Type) R. Amarillo	22e. ADDRESS Sharpsburg, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9- 3- 68	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery	23d. LOCATION (City or Town) Boonsboro, Wash. Co., Md.	(County) Boonsboro, Wash. Co., Md.	(State)		
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.	ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.	25a. REC'D BY REGISTRAR SEP 5 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



12161

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please and 2
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Harry	Middle Martin	Last Clark	2a. DATE OF DEATH Month August	Day 18	Year 1968	2b. HOUR 5:35 A.M.
3. SEX Male	4. RACE white	5. DATE OF BIRTH 11-8-1891		6. AGE (in years lost birthday) 76	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital			12a. USUAL OCCUPATION (Kind of work done during last 10 years of deceased's life, even if retired.) Self Employed	12b. KIND OF BUSINESS OR INDUSTRY Blacksmith		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1144 Kuhn, Ave.			
14. FATHER'S NAME First John	Middle Clark	15. MOTHER'S MAIDEN NAME First Flora		Middle Rowe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-10-1819	17. INFORMANT Mrs. Lillian Clark Hagerstown, Md.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>On March 10, 1968</i>	22c. DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED <i>8-19-68</i>			
22d. PHYSICIAN'S NAME (Type) Andrew M. Mandell, M. D.	22e. ADDRESS 301 E. Antietam Street Hagerstown, Md. 21740						
23c. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-21-68	23c. NAME OF CEMETERY OR CREMATORIAL Leitersburg Cemetery	23d. LOCATION (City or Town) Leitersburg, Md.	(County)	(State)		
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE AUG 23 1968			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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12142

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. **1** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First John Middle Wesley Last Cline				2a. DATE OF DEATH Month August Day 26 Year 1968				2b. HOUR 1 P													
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 31 1886		6. AGE (In years last b. birthday) 82 yrs.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN													
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington															
10. CITY OR TOWN OF DEATH Hagerstown,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1140 Jefferson Blvd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Retired															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1140 Jefferson Blvd.													
14. FATHER'S NAME First Middle Last Charles C. Cline		15. MOTHER'S MAIDEN NAME First Middle Last Sally Shupp																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 217-32-5714		17. INFORMANT Harold L. Cline Smithsburg Md R # 1		Address															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fever totemia - Ca Liver from Ca Prostate		DUE TO, OR AS A CONSEQUENCE OF (b) Ca Prostate		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo 8 yrs.															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1918																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State											
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar. 1968</u> , to <u>23 day, 1968</u> , that (I) (we) last saw the deceased alive on <u>26 Aug 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>J. D. Wilson, M.D.</u>		22c. DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED <u>8/27/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>J. D. Wilson</u>		22e. ADDRESS <u>580 NORTHERN AVE. - HAGERSTOWN, MD.</u>																			
23a. BURIAL, CREMATION, REMOVAL (SOCIETY) <u>Burial</u>		23b. DATE <u>Aug. 29/68</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) <u>Hagerstown, Washington Md.</u>		(County)		(State)											
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc.</u>		ADDRESS <u>Hagerstown, Maryland.</u>		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
				DATE <u>AUG 30 1968</u>		Signature <u>Charles J. J. J.</u>															

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

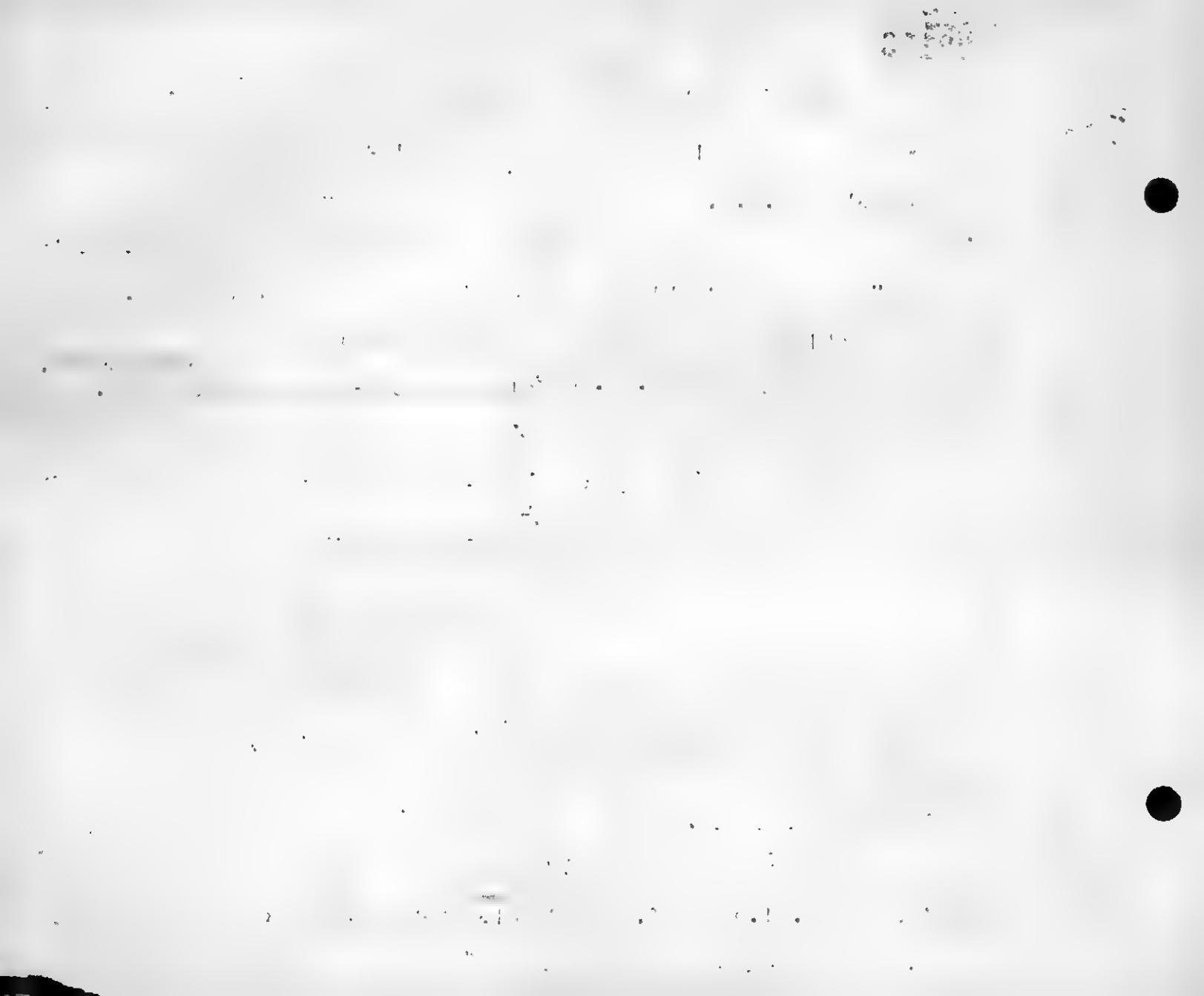
12143

CERTIFICATE OF DEATH

19152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First GEORGE	Middle WILLIAM	Last COFFMAN	2. DATE OF DEATH Month 8 Day 19 Year 68	2b. HOUR 4:10 P.M.		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JULY 24 1892		6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON				
10. CITY OR TOWN OF DEATH HANCOCK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOME		12a. USUAL OCCUPATION (Kind of work done during day or if retired) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY BUILDING		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HANCOCK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 139 FULTON ST.			
14. FATHER'S NAME First WILLIAM	Middle COFFMAN	Last	15. MOTHER'S MAIDEN NAME First ALICE STARLIPER	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO	16b. SOCIAL SECURITY NO 220.03.9682A	17. INFORMANT LILLIE M COFFMAN 139 FULTON ST.	Address HANCOCK MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 410.9 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) Passive heart failure + ASHD DUE TO, OR AS A CONSEQUENCE OF (c) Gen. arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 5/10/68 , 19, to 8/19/68 , 19, that (I) (we) last saw the deceased alive on 8/10/68 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE FB Thomas III MD.		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8/20/68		
22d. PHYSICIAN'S NAME (Type) FB Thomas III MD.		22e. ADDRESS HANCOCK WASH MD.					
23a. BURIAL, CREMATION, BURIAL	23b. DATE 8.21.68	23c. NAME OF CEMETERY OR CREMATORIUM ST. THOMAS EPISCOPAL	23d. LOCATION (City or Town) HANCOCK WASHINGTON MD.	(County)	(State)		
24. FUNERAL DIRECTOR Howard & Sonne Hancock Md	ADDRESS	25a. REC'D BY REGISTRAR AUG 23 1968	25b. REGISTRAR'S SIGNATURE James Judge				
VR AT 5.14 30M REV. 4-68							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 154

1. DECEASED NAME (Type of print)	First Allen	Middle Luther	Last Crowl	2a. DATE OF DEATH Month August	Day 8, 1968	Year 1968	2b. HOUR 1:25 A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Oct. 15, 1897		6. AGE (In years last birthday) 70	IF UNDER 1 YEAR MONTHS 9		IF UNDER 24 HRS. DAYS 23
7a. BIRTHPLACE (State or foreign country) Sharpsburg, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		12b. KIND OF BUSINESS OR INDUSTRY Aircraft		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co., Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Parts Clerk		13e. STREET AND NUMBER 417 N. Main St.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 417 N. Main St.			
14. FATHER'S NAME Charles	First Middle Crowl	15. MOTHER'S MAIDEN NAME Annie		Middle Smith	Last		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown Yes.	16b. SOCIAL SECURITY NO. 214-16-0512	17. INFORMANT Mrs. Agnes C. Crowl, 417 N. Main St.	Address Boonsboro, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos 6 mos			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastis to Bladder</i> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 199							
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town		County	State	
22a. I certify that (1) (this hospital) attended the deceased from <i>Aug 10, 1968</i> , to <i>Aug 8, 1968</i> , that (2) (we) last saw the deceased alive on <i>Aug 7, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>G. W. Luther M.D.</i>	22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED <i>Aug. 9, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>G. W. Luther</i>	22e. ADDRESS Boonsboro, Md.						
23a. BURIAL, CREMATION, REMOVAL (Type) Boonsboro	23b. DATE 8-10-68	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery	23d. LOCATION (City or Town) Boonsboro, Wash. Co., Md.	(County)	(State)		
24. FUNERAL DIRECTOR John H. East, Jr. 112 N. Main St. Boonsboro, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE AUG 12 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

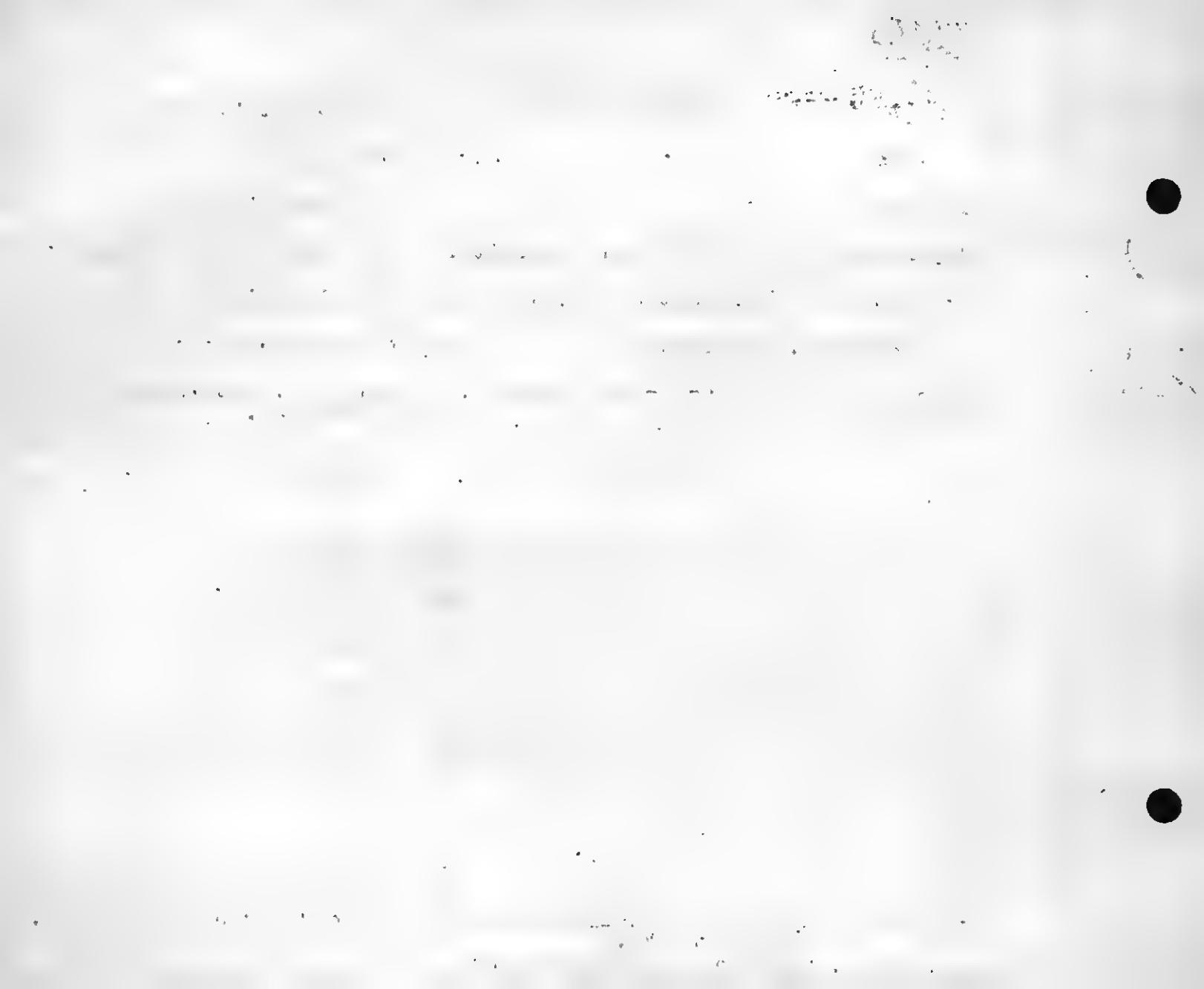
18165

15.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. ~~Postage~~ and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Harry Edwin Eshelman				2a. DATE OF DEATH Month August Day 17 Year 1968			2b. HOUR 7 P.M.		
3. SEX Male		4 RACE White		5. DATE OF BIRTH Jany 22 1897		6. AGE (In years last birthday) 71 YRS.			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Box Maker			12b. KIND OF BUSINESS OR INDUSTRY Box Factor		
13a. LSLAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Maugansville		13e. STREET AND NUMBER YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 116 Main St			
14. FATHER'S NAME First Samuel W. Eshelman		Last		15. MOTHER'S MAIDEN NAME First Mary Alberta Gearfoss		Middle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 214-09-7101		17. INFORMANT Chas R. Madden 60 E. Washington St		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 7127		DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure		Hagerstown Md		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 		(b) Atherosclerotic heart Disease not known							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Pulmonary Emphysema									
19a. DATE OF OPERATION 4		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	
22a. I certify that (I) (this hospital) attended the deceased from August 14, 1967 , to August 17, 1968 , that (I) (we) last saw the deceased alive on August 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Arturo Riego		DEGREE MD	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 119 E. Ante-Fam St. Hagerstown			
22d. PHYSICIAN'S NAME (Type) ARTURO RIEGO		22e. ADDRESS 119 E. Ante-Fam St. Hagerstown		23d. LOCATION (City or Town) (County) (State) Broadfording Wash Co Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/20/68		23c. NAME OF CEMETERY OR CREMATORIAL Dunkard Cemetery					
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D. BY REGISTRAR DATE AUG 21 1968		25b. REGISTRAR'S SIGNATURE James Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

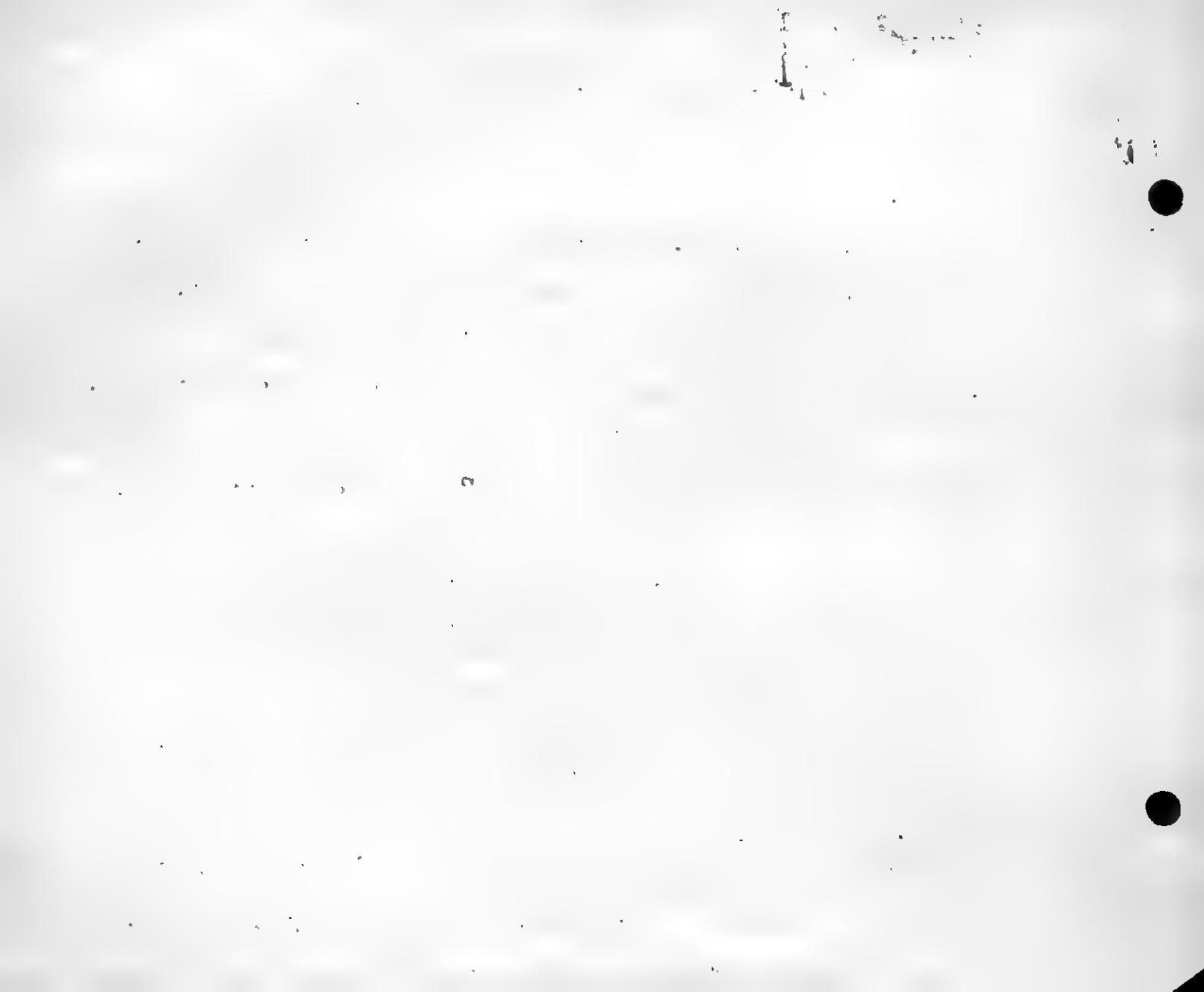
12156

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First Edna	Middle Roessner	Last Fiery	2a. DATE OF DEATH Aug Month 31 Day 68 Year	2b. HOUR M	
3 SEX female	4. RACE white	5. DATE OF BIRTH 1-18-1900	6. AGE (In years at birthday) 68 yrs.	1f UNDER 1 YEAR MONTHS	1f UNDER 24 HRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Wash.			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) wash. Co. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) teacher	12b. KIND OF BUSINESS OR INDUSTRY School			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 231 Taylor Ave.		
14. FATHER'S NAME Edgar C. Fiery	15. MOTHER'S MAIDEN NAME L. Katie Roessner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) no	16b. SOCIAL SECURITY NO 216-22-8949	17. INFORMANT John J. Fiery	Address Hagerstown, Md.			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Purulent Pericarditis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks +
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last 582 x						2 mo +
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hepatic + sub Phrenic abscess</i>						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pulmonary Emboli - Multiple</i>						
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>AUG. 19, 1968</u> , to <u>AUG. 31, 1968</u> , that (I) (we) last saw the deceased alive on <u>AUG. 31, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Lloyd A. Hoffner</i>	DEGREE ATTENDING PHYS	22c. DATE SIGNED 9/3/68				
22d. PHYSICIAN'S NAME (Type) <i>Lloyd A. Hoffner</i>	22e. ADDRESS <i>214 N. Potomac St, Hagerstown, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9-3-68	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	23d. LOCATION (City or Town) Hagerstown, Md.	County	(State)	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.	ADDRESS	25a. REC'D BY REGISTRAR SEP 5 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	2b. HOUR AM
ANNA		MARIE		FLOWERS	AUGUST 14	1968 4:30
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JANUARY 28 1906		6. AGE (in years last birthday) 62 yrs.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HANCOCK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME DAVID		15. MOTHER'S MAIDEN NAME POWELL		16. MOTHER'S MAIDEN NAME JULIA		17. STREET AND NUMBER RFD #1
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 220-26-0558		17. INFORMANT LONEY E. FLOWERS RFD #1 HANCOCK, MD.		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Acute Intestinal Obstruction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Encarcerated, Large Ventral Hernia 10 yrs.				
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION Aug 13/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small Bowel Obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town
						County
						State
22a. I certify that (I) (this hospital) attended the deceased from 8/8 1968, to 8/14 1968, that (I) (we) last saw the deceased alive on 8/14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Francisco G. Japzon		MD DEGREE ATTENDING PHYS		22c. DATE SIGNED 8/16/68		
22d. PHYSICIAN'S NAME (Type) FRANCISCO G. JAPZON		22e. ADDRESS 412 N. POTOMAC ST. HAGERSTOWN, MD. 21740				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8/17/68		23c. NAME OF CEMETERY OR CREMATORIAL ST. PAUL'S LUTHERAN		23d. LOCATION (City or Town) RURAL HANCOCK WASH. MD.
24. FUNERAL DIRECTOR Howard & George Hancock, Jr.		ADDRESS		25a. REC'D. BY REGISTRAR AUG 20 1968		25b. REGISTRAR'S SIGNATURE Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12143 CERTIFICATE OF DEATH 158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First MAUDE	Middle BLANCHE	Last FOUKE	2a. DATE OF DEATH Month AUGUST	Day 21	Year 68	2b. HOUR 5:00 a.m.			
3. SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH NOVEMBER 9, 1888		6. AGE (In years last birthday) 79		F UNDER 1 YEAR MONTHS DAYS		15 UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON						
10. CITY OR TOWN OF DEATH RURAL SANMAR	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRNEY-KEEDY NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOMEMAKER			12b. K.N.D OF BUSINESS OR INDUSTRY OWN HOME			
13a. J.S. AL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1720 JEFFERSON BLVD.						
14. FATHER'S NAME JOHN	First ANDREW	Middle MILLER	15. MOTHER'S MAIDEN NAME REBECCA	Middle SNELL	Last CRIST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 173-03-1944	17. INFORMANT MRS. THELMA HENNEBERGER HAGERSTOWN, MARYLAND	Address SHERWOOD DR. HAGERSTOWN, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.				
4107 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE 6 yrs.				
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4200										
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State			
22a. I certify that (I) (WE) attended the deceased from 11/21, 1964, to 8/21/ 1968, that (I) (WE) last saw the deceased alive on 3/25 1968 and that in (my) (WE) opinion death occurred on the date and hour and from the causes stated above, (I) (WE) (did) (did not) view the body after death.										
22b. SIGNATURE Donald E. Martin, M.D.						22c. DATE SIGNED 8/21/68				
22d. PHYSICIAN'S NAME (Type) DONALD E. MARTIN, M.D.	22e. ADDRESS 363 S. CLEVELAND, HAGERSTOWN, MARYLAND									
23a. BUR. A. CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/23/68	23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY			23d. LOCATION (City or Town) HAGERSTOWN	(County) WASHINGTON		(State) MD.		
24. FUNERAL DIRECTOR Charles M. Ragan	ADDRESS HAGERSTOWN, MARYLAND			25a. REC'D BY REGISTRAR DATE AUG 26 1968	25b. REGISTRAR'S SIGNATURE Charles J. Ragan					
VR A15 [4] 30M REV 1/68										



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

19162 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First IRA	Middle R.	Last FOX	20. DATE KNOWN OF ESTI- DEATH MATED	Month Aug.	Day 21	60 ^r 19	24 ⁴⁸ PM		
3 SEX Male	4 RACE White	5 DATE OF BIRTH May 23, 1905	6 AGE (in years last birthday) 63	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 HOURS MIN	21c DATE PRONOUNCED DEAD Month Aug.					
7a BIRTHPLACE (State or foreign country) Penns.		7b. CIT ZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Washington		22d HOUR Day 21, 1968 P.M.				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Orchard			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Penns.			13b COUNTY Franklin			13d INSIDE CITY LIM 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER RDA 2			
14. FATHER'S NAME Martin			15. MOTHER'S MAIDEN NAME Fox			16. ADDRESS Elmer H. Fox 246 S. Main St. Chambersburg, Pa.						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO. 192-37-8989			17 INFORMANT Elmer H. Fox			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hours			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thorax With Multiple Rib Fractures, Fracture Of Left Clavicle, Right Scapula, And Sternum DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 19.9			(b) Pneumothorax, Right DUE TO, OR AS A CONSEQUENCE OF (c) Laceration Of Right Lung (Rib Fractures)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) P121												
19a. DATE OF OPERATION P121			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:15 AM 8-21-68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Pinned beneath over turned farm tractor.			21d. LOCATION Street or R.F.D. No. Waynesboro, Pa.			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hess Bros. Orchard						City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Dr. E. W. Ditte, Jr.			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 8-22-68			
23a BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE Aug. 24, 1968			23c. NAME OF CEMETERY OR CREMATORIAL Brown's Mill Cemetery, Franklin, Penns.			23d. LOCATION (City or Town) Hagerstown, Md. (County) (State)			
24. FUNERAL DIRECTOR John O. Park			ADDRESS Chambersburg, Penns.			25a. RECEIVED BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE			
DATE AUG 26 1968												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12150

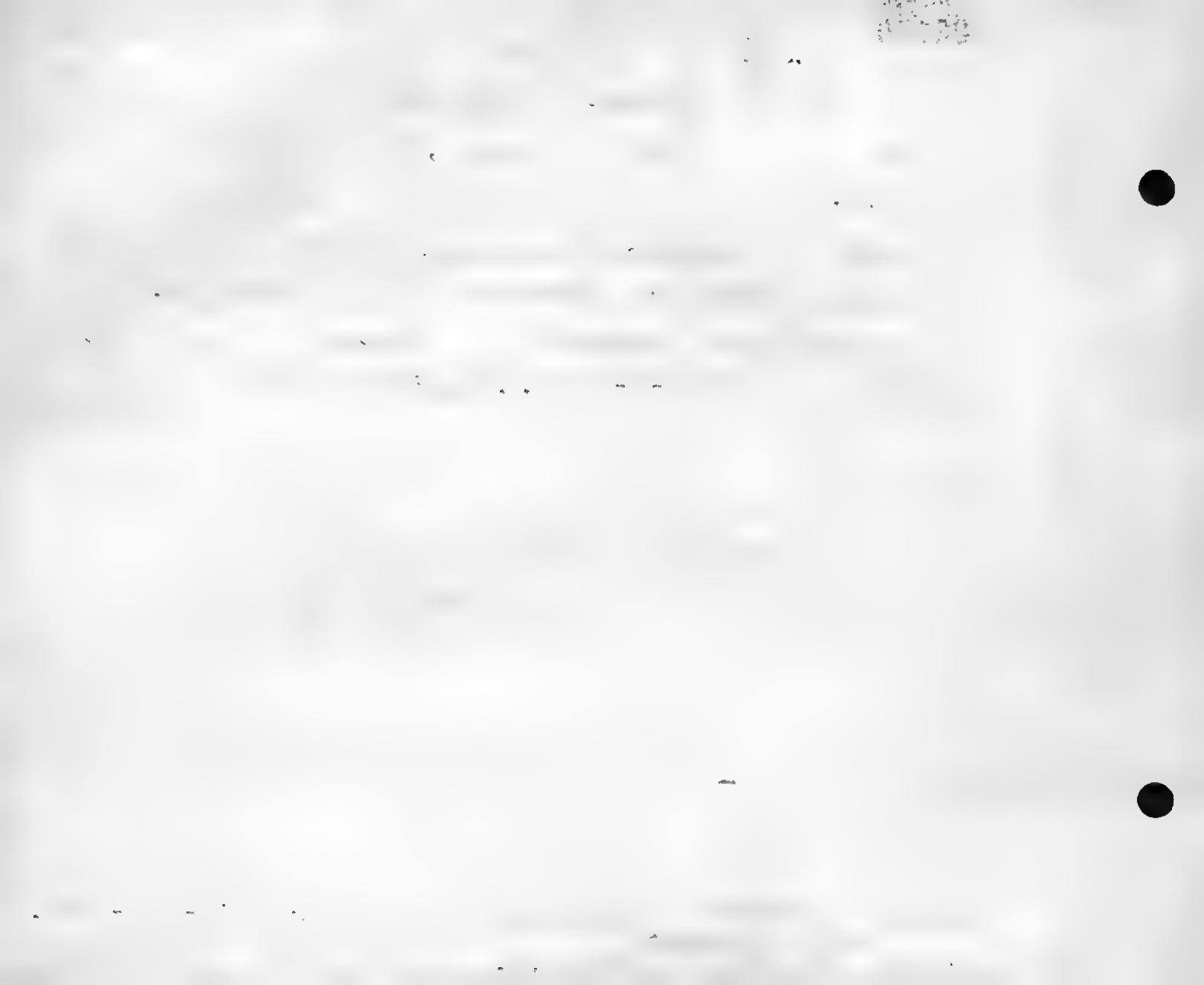
CERTIFICATE OF DEATH

12150

1. DECEASED-NAME (Type or print)	First Paul	Middle Charles	Last Fredericks	2a. DATE OF DEATH Month August	Day 25	Year 1968	2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 11, 1896		6. AGE (In years last birthday) 72	7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 MRS. DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Pottsville, Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager		12b. KIND OF BUSINESS OR INDUSTRY Hotels		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 53 Wayside Ave.				
14. FATHER'S NAME Charles Henry Fredericks	15. MOTHER'S MAIDEN NAME Elmira	16. Middle	Last	17. Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <input checked="" type="checkbox"/>	16b. SOCIA. SECURITY NO 205-09-7269	17. INFORMANT P.C. Fredericks (3/28/67)	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Diabetes								
19a. MEDICAL CERTIFICATE ON		19b. DATE OF OPERATION 4/20/1	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from 1/22/1959, to 8/24/1968, that (I) (we) last saw the deceased alive on 8/24/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE H. N. Weeks M.D.	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 8/26/68				
22d. PHYSICIAN'S NAME (Type) Howard N. Weeks, M. D.	22e. ADDRESS 580 Northern Ave., Hagerstown,							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/28/68	23c. NAME OF CEMETERY OR CREMATORIAL Pleasant View Cemetery	23d. LOCATION (City or Town) Sinking Spring-Berks Penna.	(County) Mif		(State)		
24. FUNERAL DIRECTOR W. G. House	ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.	25a. REC'D BY REGISTRAR AUG 29 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



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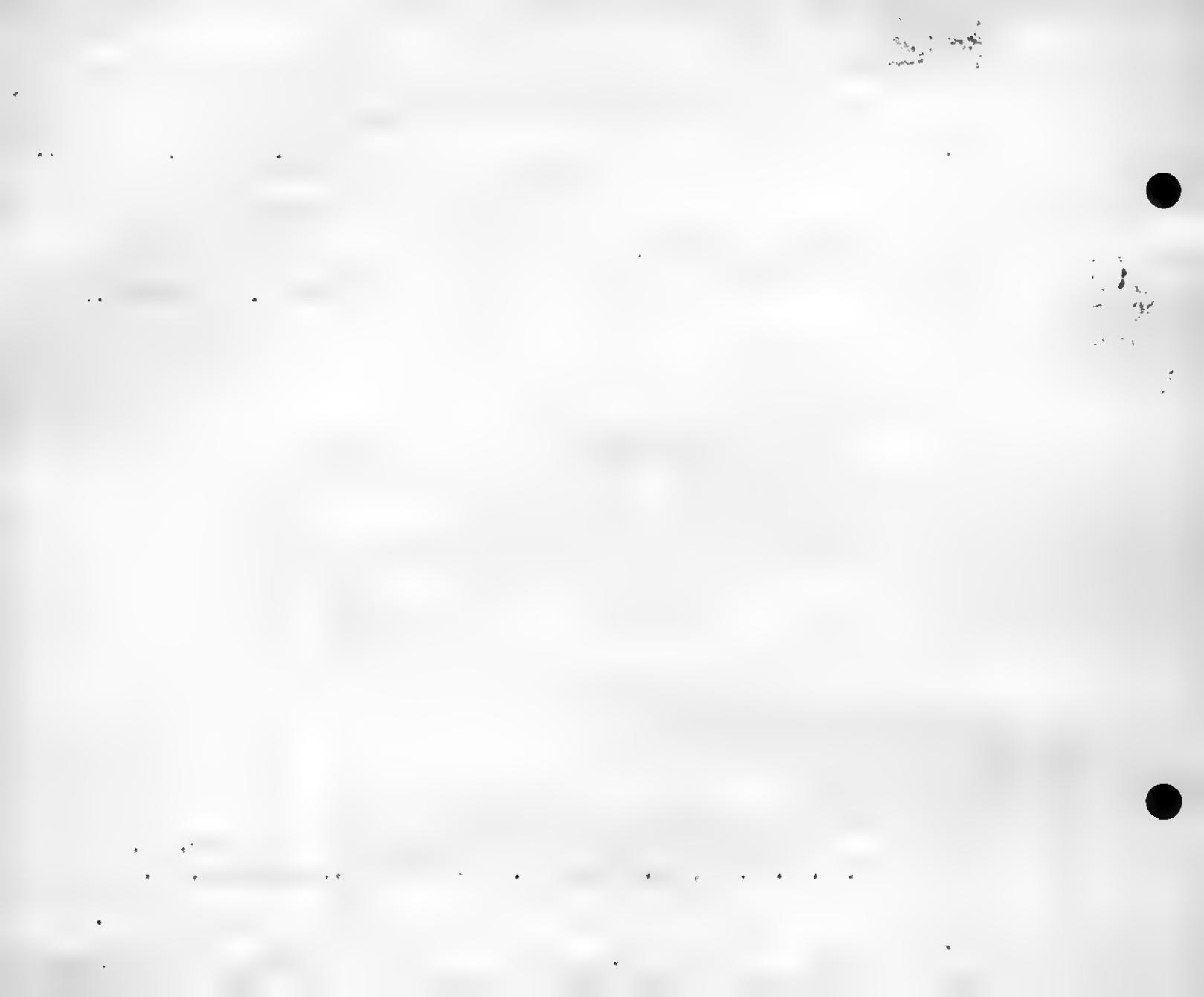
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT
BY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12151 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN <input type="checkbox"/> Month Day Year			2b HOUR <input type="checkbox"/> 4 P.M.			
Keiva			Jeanette	Gaines	DEATH ESTI MATED <input checked="" type="checkbox"/> Aug 20 1968							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN			2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR <input type="checkbox"/> 5:55 P.M.		
Female	Colored	June 6 1968	YRS 2 15				Aug. 20.	1968				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH							
Hagerstown Md		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Washington							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Hagerstown Md			Washington County Hosp.			Hagerstown			225½ N. Jonathan St., Md.			
13a USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE			13c CITY OR TOWN			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER			
Washington			Hagerstown									
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last	
Unknown						Judith Gaines						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS			
(If yes, give war or dates of service)						Judith Gaines						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Malnutrition</u>									10 weeks			
2649 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF									
			(b)									
			DUE TO, OR AS A CONSEQUENCE OF									
			(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
7720			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19c. MEDICAL CERTIFICATION												
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE 						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED Aug. 21, 1968			
Dr. E. W. Ditte, Jr.			215 W. Washington St., Hagerstown, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE Burial 8-22-1968			23c NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d LOCATION (City or Town) (County) (State) Hagerstown Md Wash.			
24 FUNERAL DIRECTOR			ADDRESS John R. Watson Jr., Hagerstown Md.			25a RECD BY REGIS RAR			25b REGISTRAR'S SIGNATURE Charles J. Juge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

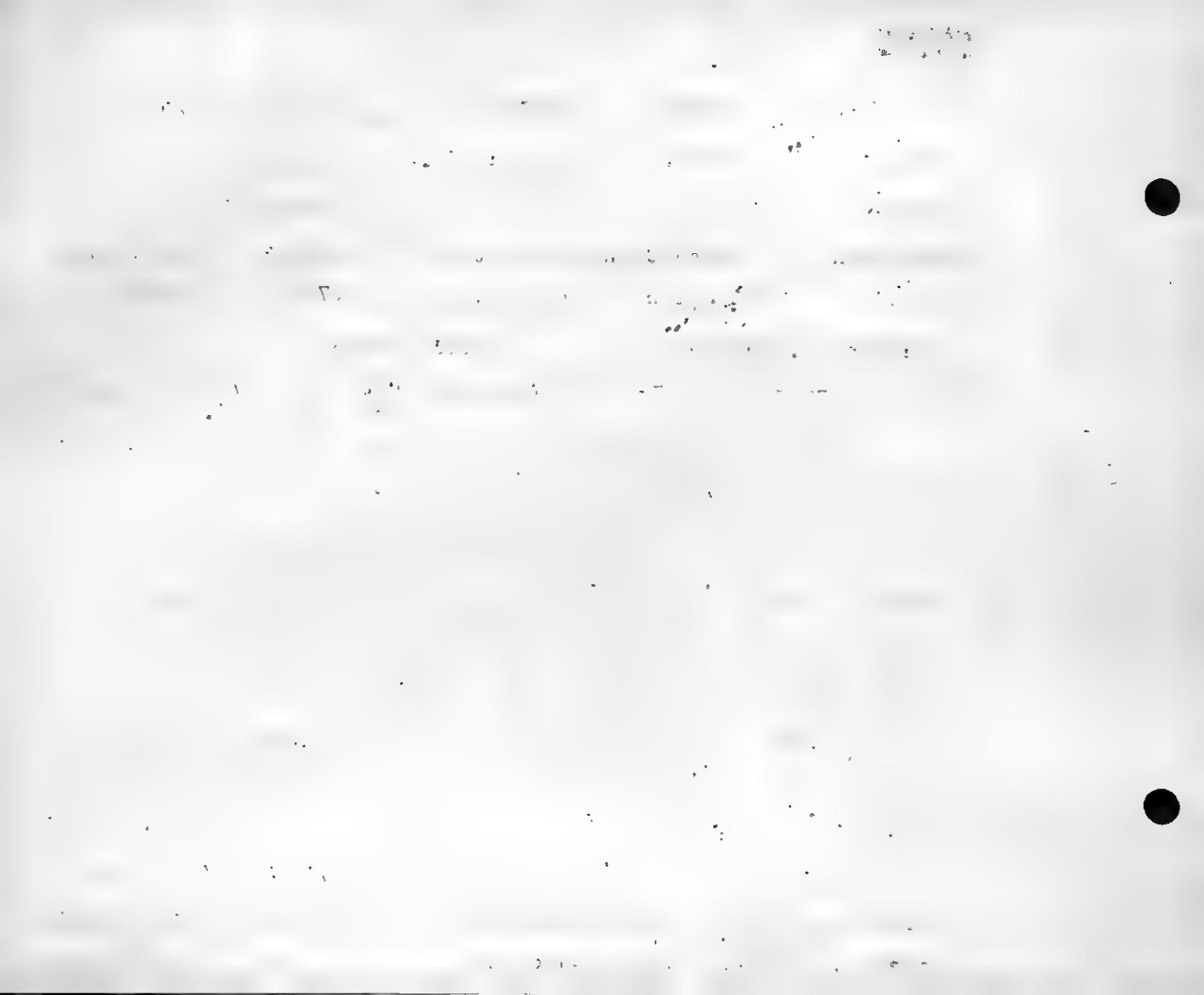
CERTIFICATE OF DEATH

166

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR 9 PM
NORA FRANCES HAMMOND			5. DATE OF BIRTH May 3 1894			6 AGE (In years last birthday) 74	
3 SEX Female		4. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9 COUNTY OF DEATH Washington	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		10. CITY OR TOWN OF DEATH Hagerstown			
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housework		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a. US AL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland				13b. CITY OR TOWN Washington		13d. INSIDE CITY J.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 1708 The Terrace				14. FATHER'S NAME Charles E. Hammond		15. MOTHER'S MAIDEN NAME First Effie Bowers	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b. SOCIAL SECURITY NO. 216-22-9467		17. INFORMANT Mrs Mabel Updegrove	
						Address 1708 The Terrace Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis				19. DATE OF OPERATION - - -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - - -			
DUE TO, OR AS A CONSEQUENCE OF (b) Arrhythmia fibrillation?				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSED DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Aug 10, 1968 , to Aug 15, 1968 , that <input type="checkbox"/> (we) last saw the deceased alive on Aug 15, 1968 and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE M.E. Byrd MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED Aug 17, 1968	
22d. PHYSICIAN'S NAME (Type) M.E. Byrd MD		22e. ADDRESS Williamsport Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/19/68		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR DATE AUG 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be re-examined within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~use~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

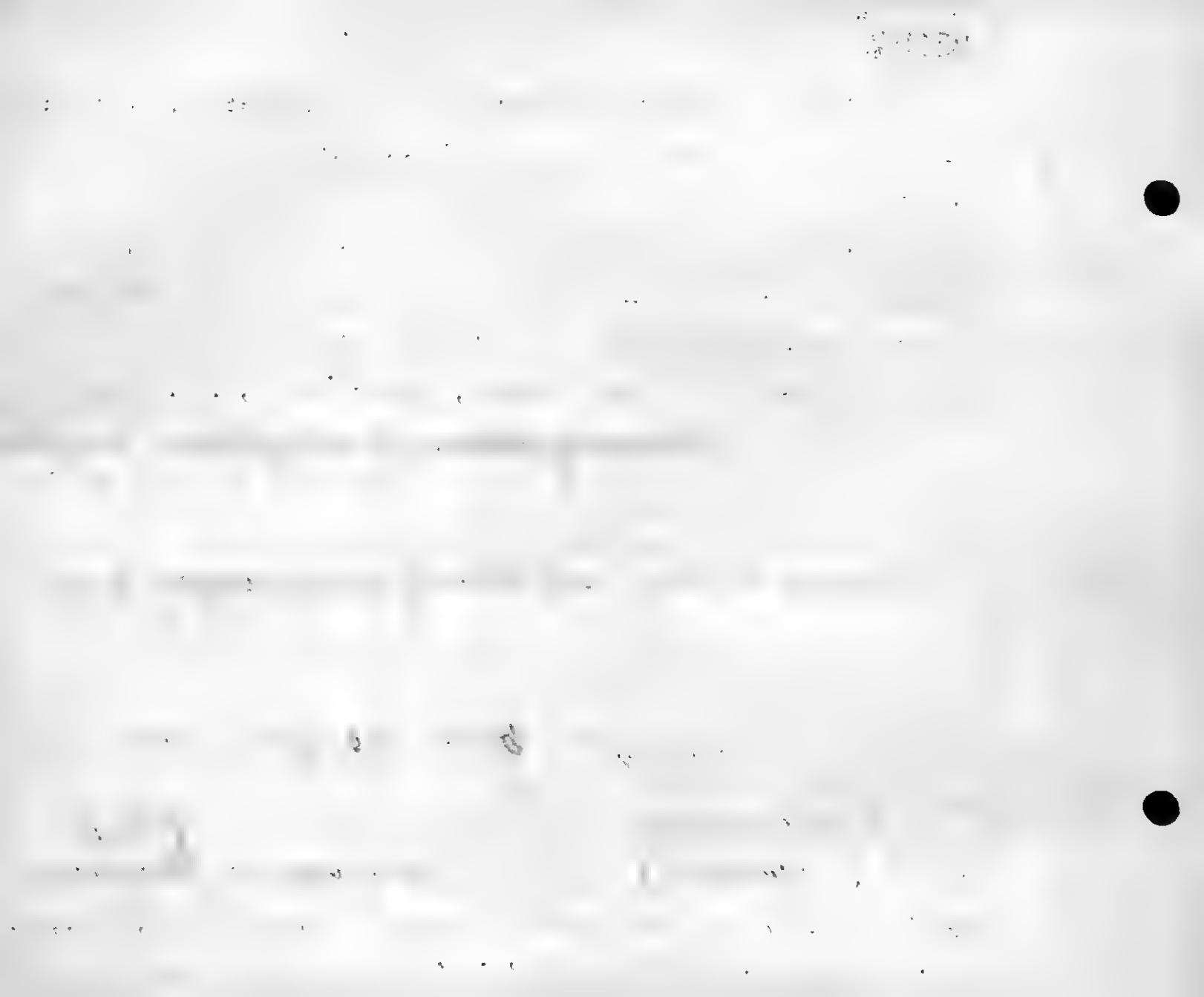
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CERTIFICATE OF DEATH

12153

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)		First JAMES	Middle ALFRBD	Last HANES	2a. DATE OF DEATH Month August	Day 24	Year 1968	2b. HOUR 8:30			
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 30, 1890		6. AGE (In years lost birthday) 78 yrs.		F UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Samples Manor		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Residence		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Samples Manor		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER John Brown Farm Road				
14. FATHER'S NAME First Christopher		Middle Columbus	Last Hanes	15. MOTHER'S MAIDEN NAME First Kathryn		Middle Anne	Last Myers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Austin E. Hanes		Address RFD# 1, Harpers Ferry, W.Va.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH more than a year			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pulmonary fibrosis and emphysema</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>195x anterior clerosis and debility with coronary heart</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <small>(If either, notify medical examiner)</small>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 612		City or Town 70		County 1968		State	
22a. I certify that (I) (this hospital) attended the deceased from 6/12 , 19 66 , to 7/2 , 19 68 , that (I) (we) last saw the deceased alive on 7/8/68 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Levannus</i>		22c. DEGREE ATTENDING PHYS.		<input type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS.		DATE SIGNED 8/25/68			
22d. PHYSICIAN'S NAME (Type) R. Amarillo		22e. ADDRESS 120 W Main St Sharpsburgh									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/27/68		23c. NAME OF CEMETERY OR CREMATORIAL Samples Manor Cemetery		23d. LOCATION (City or Town) Samples Manor, Wash., Md.		(County) (State)			
24. FUNERAL DIRECTOR <i>Donald E. Eakle</i>		ADDRESS Harpers Ferry, W.Va.		25a. REC'D BY REGISTRAR Charles J. Jones		25b. REGISTRAR'S SIGNATURE Charles J. Jones		DATE AUG 29 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
10155 CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)		First Howell			Middle Chester		Last Happ		20. DATE OF DEATH Month August 9, 1968 Year			26. HOUR 3:00A M		
3. SEX Male		4. RACE White			5. DATE OF BIRTH Jan. 7, 1903		6. AGE (In years last birthday) 65 YRS.			IF UNDER 1 YEAR MONTHS 7		IF UNDER 24 HRS HOURS 2 MIN.		
7a. BIRTHPLACE (State or foreign country) Deweyville, Texas		7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			Md.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Attorney			12b. KIND OF BUSINESS OR INDUSTRY Law						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington			13c. CITY OR TOWN Gapland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rfd.					
14. FATHER'S NAME John		First Middle Happ			15. MOTHER'S MAIDEN NAME Dora			Middle Last Collier						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.		16b. SOCIAL SECURITY NO. 463-24-8645			17. INFORMANT Mrs. Marjorie Happ, Gapland, Maryland			Address						
18. CAUSE OF DEATH (Enter on a separate line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 3 hr 4109 Conditns, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis neck coronary vessels</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>frequency</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 47201														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/9/68</u> to <u>death</u> at <u>3 pm 8/9/68</u> , that (I) (we) last saw the deceased alive on <u>8/9/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Dr. Amarillo</u>		22c. DEGREE ATTENDING PHYS.			22d. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22e. DATE SIGNED <u>8/9/68</u>						
22d. PHYSICIAN'S NAME (Type) <u>R. Amarillo</u>		22e. ADDRESS <u>Sharpsburg, Md.</u>												
23d. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-12-68			23c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery			23d. LOCATION (City or Town) Boonsboro, Wash. Co., Md.			(County) (State)			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS Boonsboro Cemetery			25a. REC'D BY REG. STRR DATE AUG 12 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10155

1165

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
Washington MARYLAND		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD-1 Clear Spring, Md.	
c. LENGTH OF STAY IN 1b Two Hrs.		d. STREET ADDRESS RFD-1 Clear Spring, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Clyde	Middle Wilbur	Last Hart
4. DATE OF DEATH	Month August	Day 10	Year 1968
5. SEX	6. COLOR OR RACE Male White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1913
	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery man		10b. KIND OF BUSINESS OR INDUSTRY Florist	
11. BIRTHPLACE (County & State, or foreign country) Morgan County W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur G. Hart		14. MOTHER'S MAIDEN NAME Mary Beard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. 214-16-0694	
17. INFORMANT Mrs. Alice Hart		Address RFD-1 Clear Spring	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		Acute Myocardial Infarction	
DUE TO (b) Arteriosclerotic heart disease.		Arteriosclerotic heart disease.	
DUE TO (c) Arterial sclerosis, General		Arterial sclerosis, General	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 42.1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 1968, to <u>Aug. 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug. 10, 1968</u> , and that death occurred at <u>2pm</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur G. Hart</u>		22b. DATE SIGNED 1968	
22c. PHYSICIAN'S NAME (Type) Arthur G. Hart		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS 119 E. Anheuser St.		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 13, 68	
23c. NAME OF CEMETERY OR CREMATORIUM Shanktown		23d. LOCATION (City, town or county) (State) Shanktown Maryland	
24. FUNERAL DIRECTOR Edward E. Thompson		ADDRESS	
Thompson Funeral Home		25a. REC'D BY REGISTRAR AUG 15 1968	
Clear Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

101166
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First	Middle	Lost	2a DATE KNOWN OR ESTI- MATED		Month	Day	Year	
Mabel Geraldine Hawn						<input checked="" type="checkbox"/>	<input type="checkbox"/>	Aug. 25	168	M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER MONTHS	YEAR DAYS	8 IF UNDER 24 HRS HOURS	MIN.	2b HOUR			
Female	White	March 11, 1928	40 yrs	5	13			2d HOUR			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	9. COUNTY OF DEATH			
Maryland		USA						Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown			DOA Washington Co. Hosp.			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution admits on) STATE			13c CITY OR TOWN			13d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Washington Hagerstown						R.F.D. #2		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Wilbur						Kendall			Mamie		Snyder
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
No			215-42-3932			Mrs. Wilbur Kendall			RFD #2 Smithsburg, Md.		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
(b) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) _____ Rheumatic Heart disease										YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 416x											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20. AUTOPSY?		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			2. b. TIME OF INJURY Month, Day Year HOUR A.M. P.M.		2. c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21b INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21c PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21d LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22b DATE SIGNED 8/27/68	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> Howard N. Weeks M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Hagerstown, Md.								
23a. BURIAL, CREMATION REMOVAL (Specify)			23b DATE Aug. 28, '68		23c NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		23d LOCATION (City or Town) (County) (State) Hagerstown, Wash., Maryland				
Burial											
24. FUNERAL DIRECTOR			ADDRESS		25a REC'D BY REGISTRAR DATE AUG 29 1968			25b REGISTRAR'S SIGNATURE J. L. Leaf			
Albert L. Leaf			Williamsport, Md.								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

167

12157

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 9:20 P.M.
LEAH H. HEGE				Aug 1 1968	
3. SEX Female	4 RACE White	5. DATE OF BIRTH 5/13/1890		6. AGE (In years last birthday) 78	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Wash. Co., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH R.D. Clearsprng, md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. Clearsprng, md.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN -	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.D.-Clearsprng, md.	
14. FATHER'S NAME John	First W.	Middle Martin	Last	15. MOTHER'S MAIDEN NAME Amanda	HORST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	16b. SOCIAL SECURITY NO.	17. INFORMANT Henry Hege	18. ADDRESS Clearsprng, md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Adeno Carcinoma Colon</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 5, 1968</u> , to <u>Aug. 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>7-29- 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <u>E. W. Ditto</u>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED Aug. 2, 1968
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22e. ADDRESS 215 W. Washington St., Hagerstown, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 8/5/68	23c. NAME OF CEMETERY OR CREMATORIUM Reiff Ch. Cem.	23d. LOCATION (City or Town) near Garfield, Md.	(County) (State)
24. FUNERAL DIRECTOR ADDRESS A. W. Munich - Greencastle, Penna.		25a. REC'D BY REGISTRAR AUG 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

$\lambda_1 = \lambda_2 = \lambda_3$

$\lambda_1 = \lambda_2 = \lambda_3$

$\lambda_1 = \lambda_2 = \lambda_3$

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12158

CERTIFICATE OF DEATH

1168

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)				First HARRY	Middle ELMER	Last HOUSE	2a. DATE OF DEATH Month August	Day 15	Year 1968	2b. HOUR 9:05 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 28, 1889			6. AGE (in years last birthday) 78 yrs.			IF UNDER 24 MRS. MONTHS 11			
7a. BIRTHPLACE (State or foreign country) Middletown, Rt. 1		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Washington							
10. CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES		13e. STREET AND NUMBER Middletown							
14. FATHER'S NAME First Charles		Middle House	Last	15. MOTHER'S MAIDEN NAME First Katie		Middle	Last Mozer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-36-0118		17. INFORMANT Mrs. Mary House, Rt. # 1, Middletown, Md.			Address						
18. CAUSE OF DEATH (Enter on a line cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 12.1		(b) Cardiac insufficiency					(c)						
DUE TO, OR AS A CONSEQUENCE OF											1 day		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from Aug 10, 1968 to Aug 15, 1968 , that (I) (we) last saw the deceased alive on Aug 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <i>G. W. Hevan</i>		22c. DEGREE MD		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS.		DATE SIGNED Aug 16, 1968			
22d. PHYSICIAN'S NAME (Type) G. W. Hevan		22e. ADDRESS Boonsboro, Md.											
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-18-68		23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery		23d. LOCATION (City or Town) Boonsboro, Wash. Co., Md.		(County)		(State)			
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS		25a. REC'D. BY REGISTRAR AUG 20 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12159

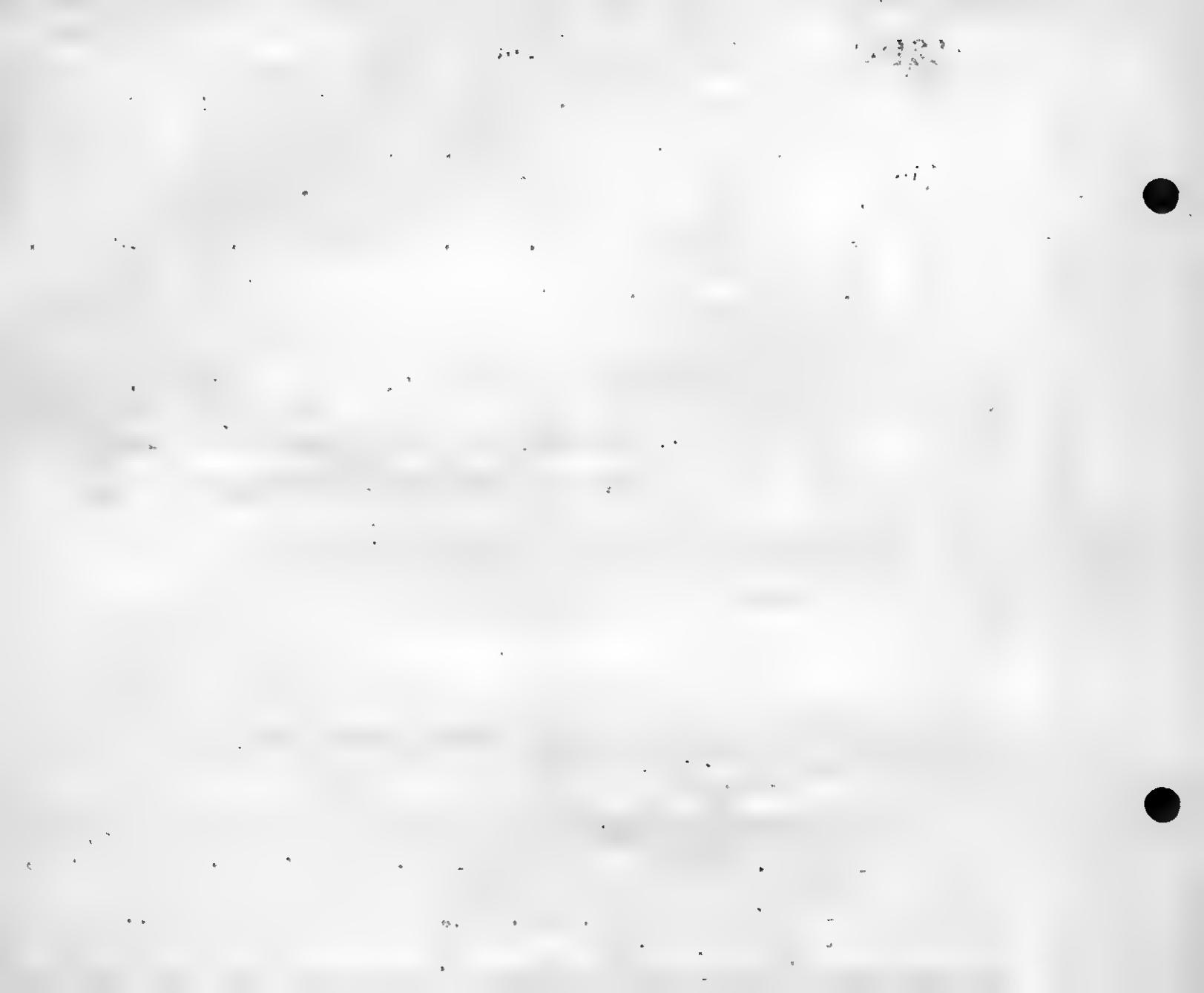
CERTIFICATE OF DEATH

2169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers, ~~page 3~~ on 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Russell Paul Howe	Middle Sr.	Lost	2a. DATE OF DEATH Month Aug. 27 1968	2b. HOUR 10:00
3. SEX male	4 RACE white	5. DATE OF BIRTH Oct. 25, 1894		6. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penns.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most working life, even if retired) Hotel Op.		12b. KIND OF BUSINESS OR INDUSTRY Own Bus.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Fred.	13c. CITY OR TOWN Lantz	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RD 1	
14. FATHER'S NAME Jacob Howe	First Middle Lost	15. MOTHER'S MAIDEN NAME Anna Snively	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes, no, or unknown)	16b. SOCIAL SECURITY NO 175-03-4385	17. INFORMANT Bessie G. Howe	Address Lantz, Md. RD 1		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF instant Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> many years last. (b) <u>atherosclerotic heart disease</u> (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE DISEASE GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>7/22</u> , 19 <u>68</u> , to <u>8/27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug 15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edson B. Moody</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>Aug 27, 1968</u>
22d. PHYSICIAN'S NAME (Type) Edson B. Moody		22e. ADDRESS 115 S. Prospect St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-30-68	23c. NAME OF CEMETERY OR CREMATORIUM Phila. Mem. PARK CEM.	23d. LOCATION (City or Town) Wilmington, Del.	(County) (State)
24. FUNERAL DIRECTOR Raymond E. Creager		ADDRESS Thurmont, Md.	25a. REC'D BY REGISTRAR AUG 30 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
			DATE		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

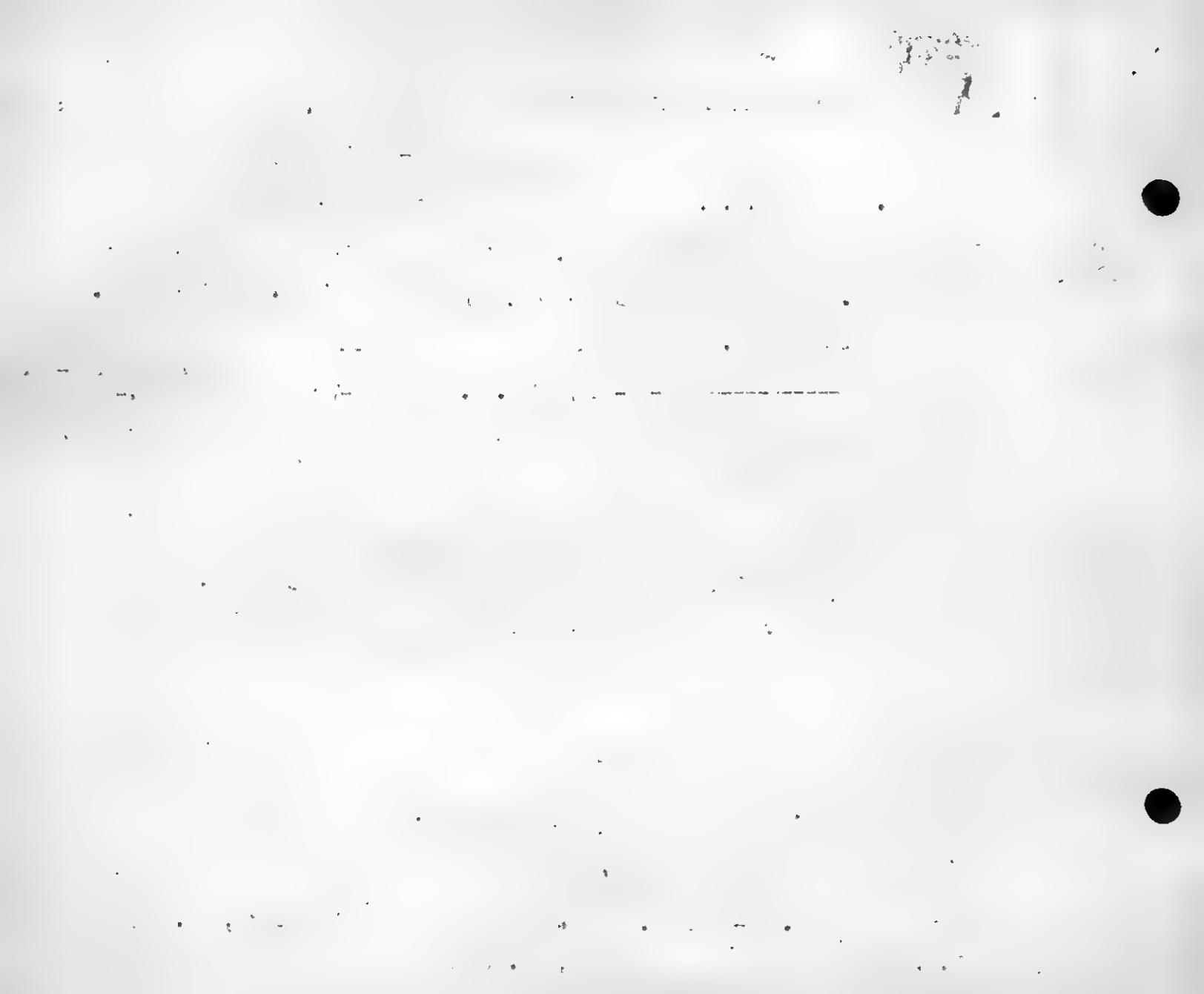
12160

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	2b. HOUR Day
George William Smith Hunichen				Aug.	68
3. SEX Male	4 RACE White		5 DATE OF BIRTH August 6- 1897		6 AGE (In years last birthday) 71
7a BIRTHPLACE (State or foreign country) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 COUNTY OF DEATH Washington	
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp.tol give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Furniture Refinisher	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 21 W. Washington St.
14. FATHER'S NAME Albert	Middle S.	Last Hunichen	15 MOTHER'S MAIDEN NAME Ida	Middle	Last Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. If yes give war or dates of service 215-20-9157		17 INFORMANT Geo. A. Hunichen-7 South French St. -	Address Alexandria-Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>General Metastasis of Carcinoma</i>					
19a. DATE OF OPERATION 1968	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of Esophagus</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Wife</i>		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 23 1968</i> , to <i>Aug 23 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug 23 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John Deady M.D.</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE STONED <i>8/24/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>John Deady M.D.</i>	22e. ADDRESS <i>Hagerstown, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE Aug. 28-1968	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	23d. LOCATION (City or Town) Frederick, Md. 21701	(County)	(State)
24. FUNERAL DIRECTOR M.R. Etchison & Son	ADDRESS <i>Whitmore</i> Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE <i>AUG 28 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Etchison</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12161

12171

1. PLACE OF DEATH

2. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Martin Manor Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

AGNES SAVILLA JAMISON

4. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

Last

4. DATE
OF
DEATH

August 23,

1968

9

AGE (in years
last birthday)

10

IF UNDER 1 YEAR

11

IF UNDER 24 HRS.

75

yrs.

Months

Days

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Bakerton, West Va.

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

Charles Ingram

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

215-34-3863

17. INFORMANT

Thurman Jamison,

Address 211 W. Antietam S

Sharpesburg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

b)

DUE TO

(c)

Acute Intestinal obstruction,
malignant mediastinal Hernia
Hepatic Sclerotic Disease -INTERVAL BETWEEN
ONSET AND DEATH

12 hr.

24-36 hr

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

While

at work

Not While

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

Aug. 27, 1968 to Aug. 23, 1968

, that (I) (we) last

saw the deceased alive on June 27, 1968

, and that death occurred at 12 M

from the causes and on the date stated above.

22a. SIGNATURE

Edward W. Ditto, III, MD.

8/23/68

22b. DATE SIGNED

ATTENDING
PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

217 W. Washington Street

Hagerstown,

Maryland

23d. LOCATION (City, town or county)

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

24. FUNERAL DIRECTOR'S SIGNATURE

Burial 8/26/68

Samples Manor, Cemetery

ADDRESS

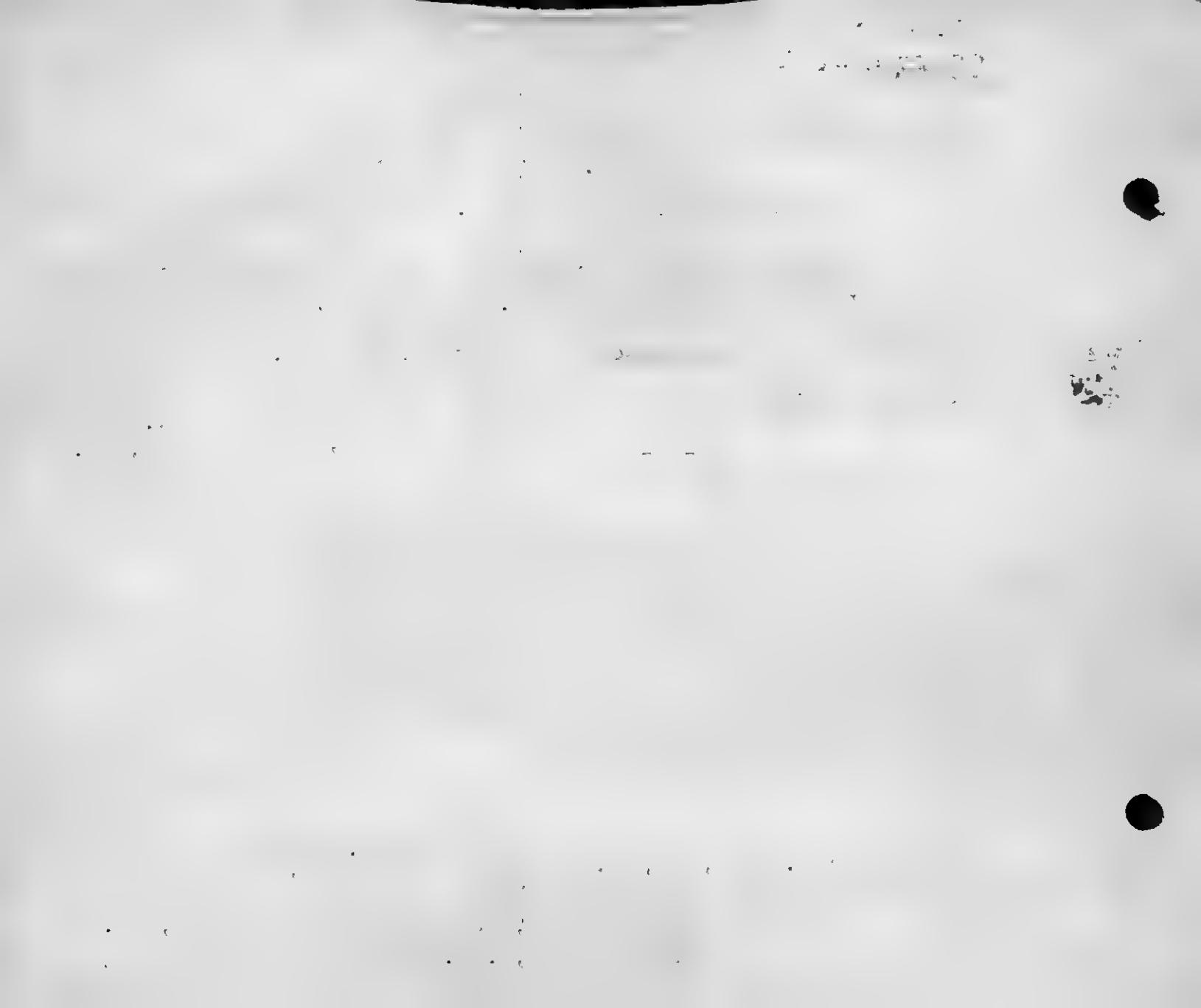
Harpers Ferry, W. Va.

AUG 26 1968

james jones

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First CHARLES	Middle EARL	Lost KAETZEL	2a. DATE OF DEATH Month AUGUST	Day 24	Year 1968	2b. HOUR 355 P.M.					
3. SEX male		4. RACE white	5. DATE OF BIRTH 10-18-1892			6. AGE (In years last birthday) 75		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. MONTHS 0				
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON								
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Moulder			12b. KIND OF BUSINESS OR INDUSTRY Sand Blast Equipment					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Chewsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 27						
14. FATHER'S NAME First Lewis P. Kaetzel			15. MOTHER'S MAIDEN NAME First Laura Fouch											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give name or dates of service) 214-09-6030A		17. INFORMANT Mrs. Marion R. Kaetzel		Address Chewsville, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
DUE TO, OR AS A CONSEQUENCE OF (d)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No WESTERN MD. STATE HOSPITAL		City or Town Hagerstown, Md.		County Hagerstown, Md.		State Md.			
22a. I certify that (I) (this hospital) attended the deceased from 3-6 , 19 68 , to 8-24 , 19 68 , that (I) (we) last saw the deceased alive on 8-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Domino A. Garcia												22c. DATE SIGNED August 24, 1968		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS WESTERN MD. STATE HOSPITAL												
23a. BURIAL, CREMATION, REMOVAL. (Specify) Burial		23b. DATE 8-27-1968		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION (City or Town) Hagerstown, Md.		(County) Hagerstown, Md.		(State) Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS			25a. REC'D BY REGISTRAR Charles J. Judge		25b. REGISTRAR'S SIGNATURE Charles J. Judge							

1918.2.1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED NAME (Type or print)	First <i>Lulu</i>	Middle <i>Mar</i>	Last <i>Kaylor</i>	2a. DATE OF DEATH Month <i>August</i>	Day <i>24</i>	Year <i>1968</i>	2b. HOUR <i>4:15p.m.</i>		
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>JULY 25, 1885</i>		6. AGE (In years last birthday) <i>83</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>WASHINGTON</i>					
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WESTERN MD. STATE HOSPITAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOME MAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>WASHINGTON</i>	13c. CITY OR TOWN <i>HAGERSTOWN</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>433 N. POTOMAC STREET</i>					
14. FATHER'S NAME First <i>ALAN</i>	Middle <i>DENTON</i>	Last <i>EAKLE</i>	15. MOTHER'S MAIDEN NAME First <i>LAURA</i>	Middle <i>MIDDLEKAUFF</i>	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>	16b. SOCIAL SECURITY NO. <i>-----</i>	17. INFORMANT <i>MR. HARRY W KAYLOR</i>	433 Address <i>N. POTOMAC ST.</i>	HAGERSTOWN, MARYLAND					
18. CAUSE OF DEATH (Enter on y. one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerosis heart disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>(b)</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No	City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>7-22, 1968</i> , to <i>8-24, 1968</i> , that (I) (We) last saw the deceased alive on <i>8-24, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Domingo A. Garcia</i>		DEGREE <i>DOMINGO A. GARCIA</i>	ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>August 24, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>DOMINGO A. GARCIA</i>		22e. ADDRESS <i>WESTERN MARYLAND STATE HOSPITAL</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>8/27/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>REST HAVEN CEMETERY</i>		23d. LOCATION (City or Town) <i>HAGERSTOWN</i>	(County) <i>WASHINGTON</i>	(State) <i>MD.</i>		
24. FUNERAL DIRECTOR <i>Charles M. Renger</i>		ADDRESS <i>HAGERSTOWN, MARYLAND</i>		25a. REC'D BY REGISTRAR <i>Charles M. Renger</i>	25b. REGISTRAR'S SIGNATURE <i>Charles M. Renger</i>	DATE <i>AUG 30 1968</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18166

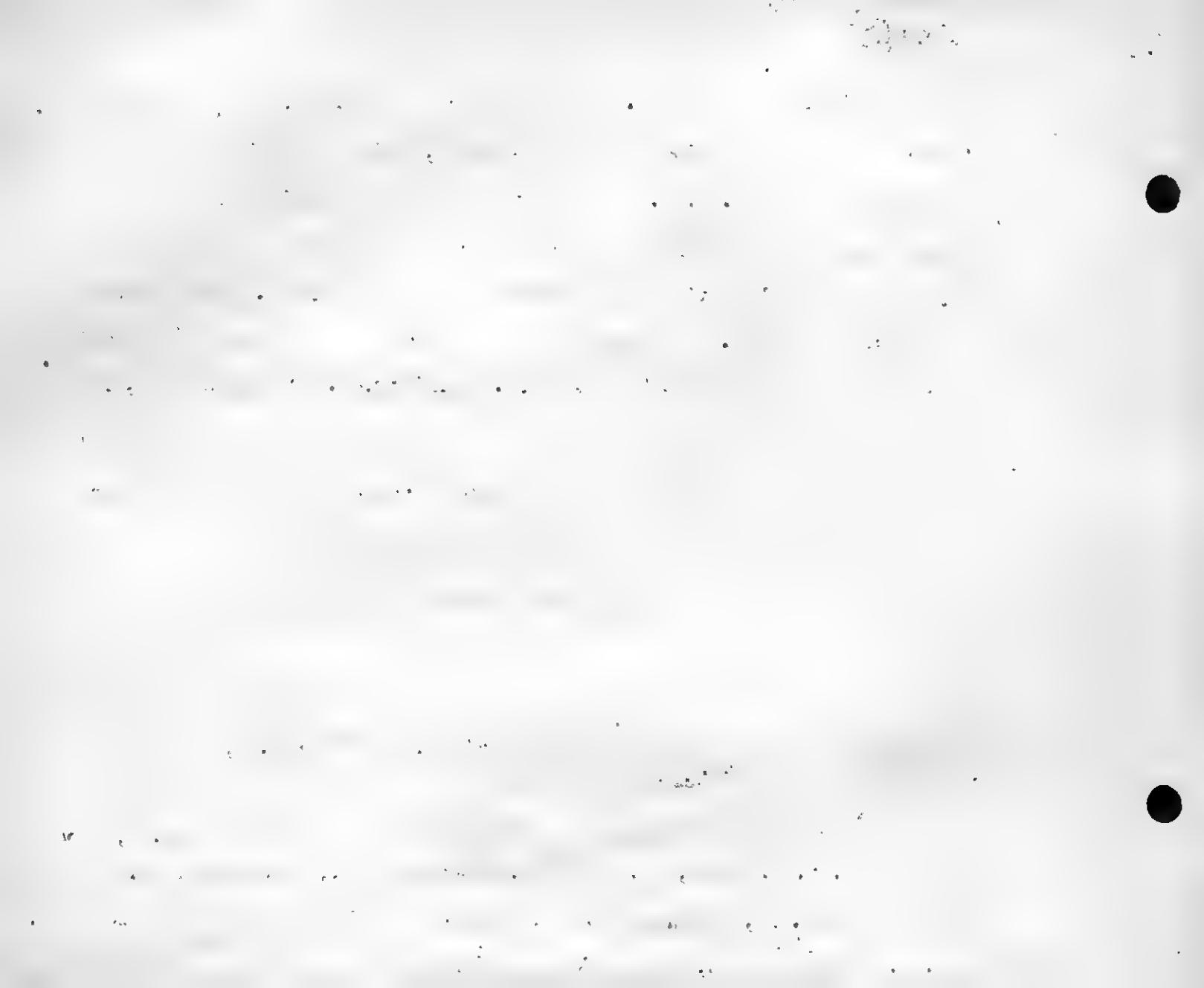
CERTIFICATE OF DEATH

174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Lillie	Middle I.	Last Keefer	2a. DATE OF DEATH Month August	Day 9	Year 1968	2b. HOUR AM. 2:50
3. SEX Female	4. RACE White	5. DATE OF BIRTH June 29, 1875			6. AGE (in years last birthday) 93	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN. 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington			Md.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Martin Manor Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S. AL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 412 W. Second Street			
14. FATHER'S NAME First George	Middle W.	Last Smith	15. MOTHER'S MAIDEN NAME First Mary	Middle Jane	Last Burrier	Address Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 220 48 3926	17. INFORMANT Mrs. John Renn, Jr.			Approximate Interval Between Onset and Death 3 day's		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis							
4129 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio Vascular Disease							
DUE TO, OR AS A CONSEQUENCE OF (c)							
5 years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
4221							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from March 21, 1967 , to Aug. 9, 1968 , that (I) (we) last saw the deceased alive on Aug. 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <input type="checkbox"/> view the body after death							
22b. SIGNATURE <i>H. E. W. Ditte</i>				22c. DATE SIGNED Aug. 9, 1968			
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 215 W. Washington St., Hagerstown, Md.			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 12, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	23d. LOCATION (City or Town) Frederick	(County) Frederick	(State) Md.		
24. FUNERAL DIRECTOR <i>Donald M. Faderley</i>	ADDRESS M. R. Etchison & Son, Frederick, Maryland	25a. REC'D BY REGISTRAR AUG 13 1968	25b. REGISTRAR'S SIGNATURE <i>John D. Judge</i>				

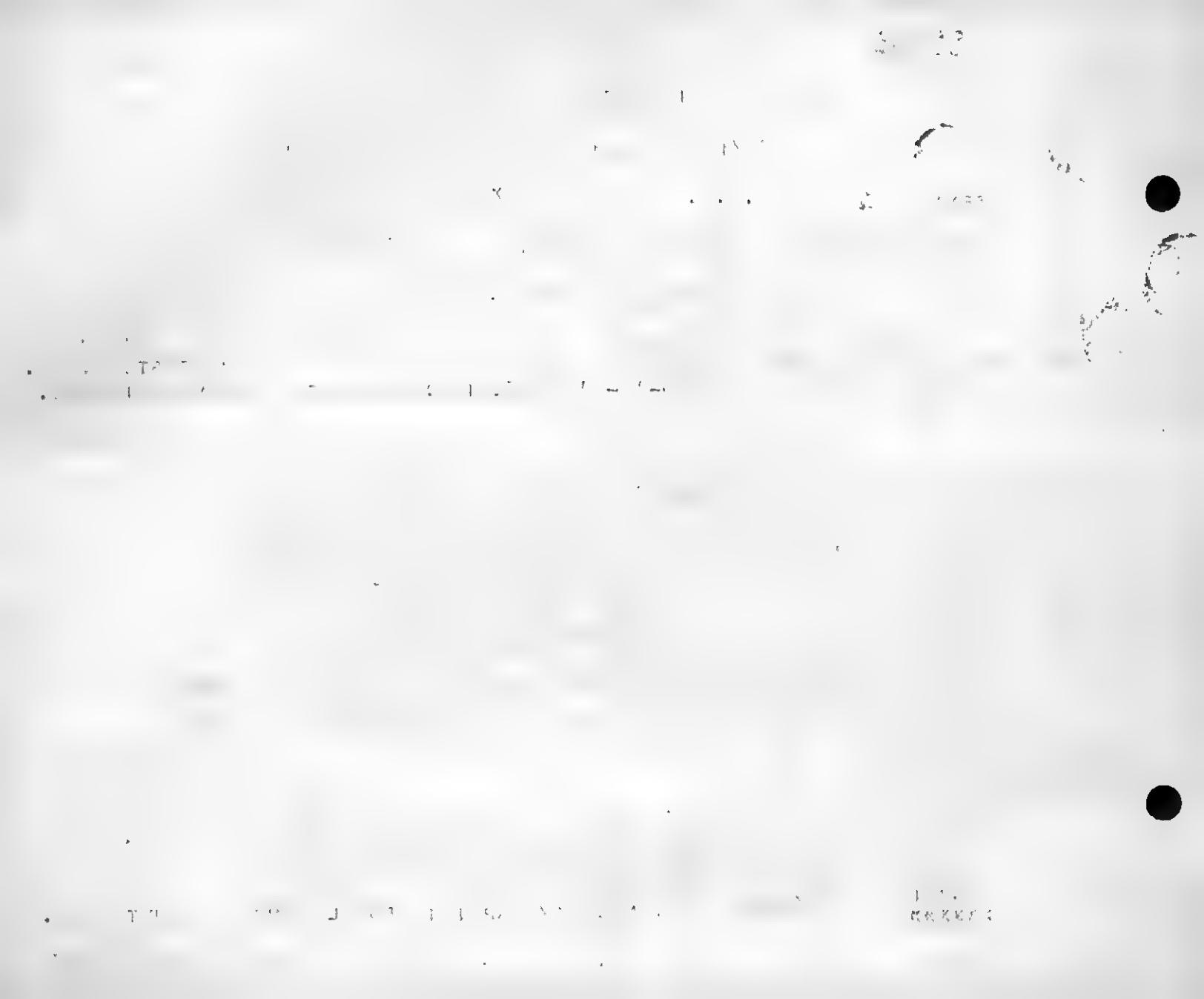


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1816 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH MATED			Month	D.	Year
HANNAH ELIZABETH KELLEY						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8/6/	19	68 P.M.
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years at birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2b DATE PRONOUNCED DEAD 8 Mon 6/68 Day			2d HOUR Year	2b DATE PRONOUNCED DEAD 8 Mon 6/68 Day	
F	W	4/2/1887	81 YRS			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19	9:30 P.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY			
TEXAS		U.S.A.				WASHINGTON					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or nursing home, give address)			12a. USUAL OCCUPATION (Kind of work done during regular working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN, MD			WASHINGTON COUNTY			HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e STREET AND NUMBER					
MD		WASHINGTON HAGERSTOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MARRIED NAME			First	Middle	Last
GEORGE				WEAVER		DORA					MARTIN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			ADDRESS		
NO			293-14-7148A			ELSIE KERSHNER			HAGERSTOWN, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF <u>Sudden</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic disease</u> Years											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Nephrosclerosis with uremia & fracture of left hip.											
19a. MEDICAL CERTIFICATE ON DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
8/2/68			Fracture of left hip.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR AM			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
7:10 P.M.			7/30/68			Patient fell out of wheel chair					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WORKING AT WORK <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)			21f. LOCATION Street or RFD No City or Town County State					
			Coffman Home for the Aging, Hagerstown, Maryland			Pennsylvania Avenue					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Howard N. Weeks			CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)			Howard N. Weeks, M. D., Hagerstown, Maryland			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL/CREMATION, BUT NOT BOTH			23b. DATE 8/9/68			23c. NAME OF CEMETERY OR CREMATORIAL TONOLOWAY BAPTIST RURAL HANCOCK FULTON PA.			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Howard & Groves Hancock Md						DATE AUG 15 1968			Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12165

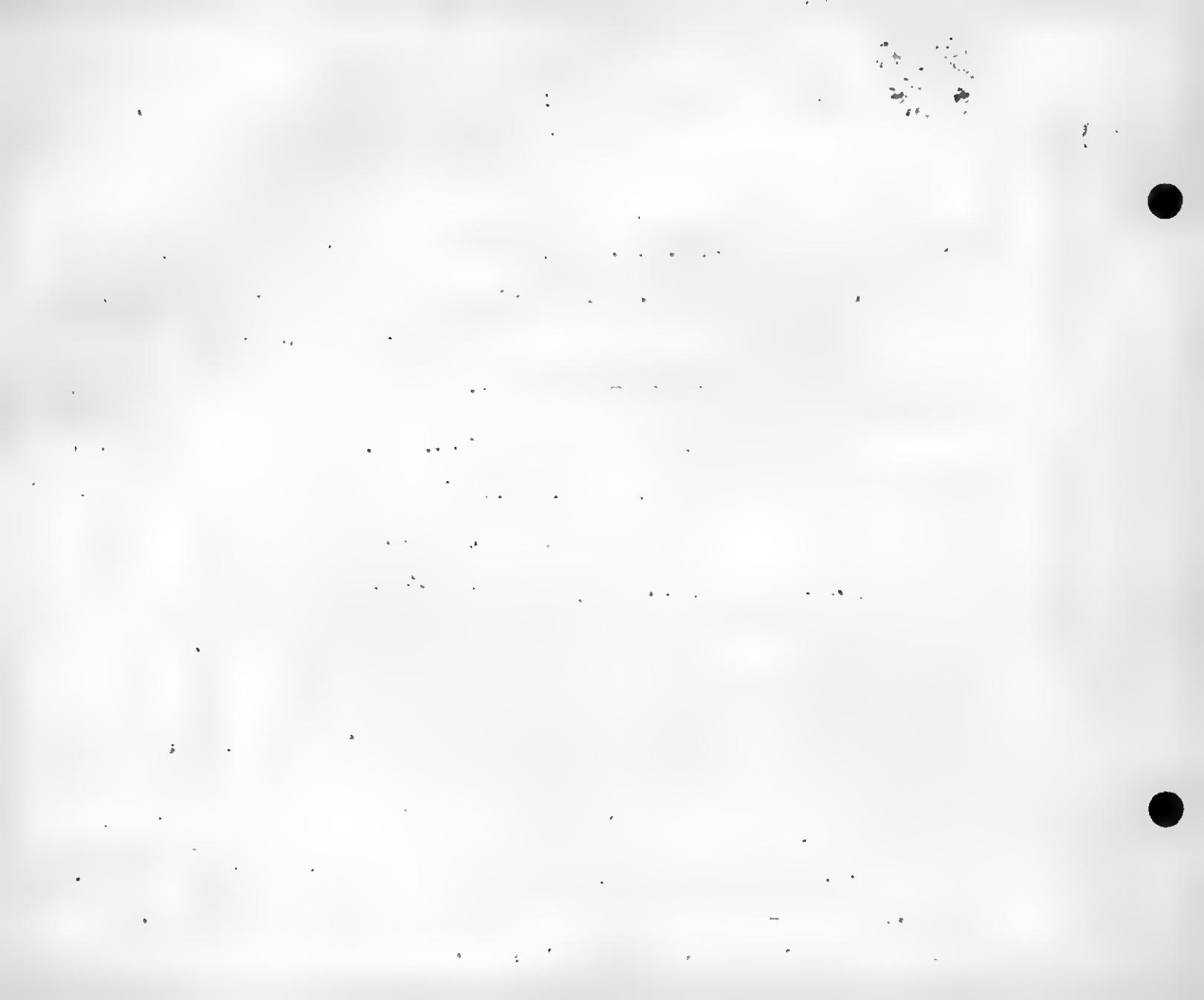
CERTIFICATE OF DEATH

12176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1 DECEASED NAME (Type or print)	First John	Middle August	Last Kern	20 DATE OF DEATH Month August Day 30, 1968 Year	2b HOUR M		
3 SEX male	4 RACE white	5. DATE OF BIRTH Aug. 16, 1894		6 AGE (in years last birthday) 74	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		12b KIND OF BUSINESS OR INDUSTRY railroad		
10. CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital Wash. Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during past year, even if retired)		13e STREET AND NUMBER 100 Fairground Ave.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Md.	13b COUNTY Wash.	13c CITY OR TOWN Hagerstown	3d INSIDE CITY & MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 100 Fairground Ave.			
14 FATHER'S NAME First Adam Kern	Middle	Last	15. MOTHER'S MAIDEN NAME First Frieda Dieringer	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no	16b. SOCIAL SECURITY NO 705-10-5741	17. INFORMANT Mrs. Alice Kern, Hagerstown, Md.	Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause		DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis		4 yrs			
		DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease		3 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Active pulmonary tuberculosis							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/9, 1965, to 8/30, 1968, that (I) (we) last saw the deceased alive on 8/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald E. Martin	DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 8/31/68		
22d. PHYSICIAN'S NAME (Type) Donald E. Martin M.D.	22e. ADDRESS 363. S. Cleveland Ave (Wash) Md.						
23a. BURIAL, CREMATION, REMOVED	23b. DATE 9-2-68	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	23d. LOCATION (City or Town) Hagerstown, Md.	(County)	(State)		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.	ADDRESS	25a. RECD BY REGISTRAR DATE SEP 3 1968	25b. REGISTRAR'S SIGNATURE James Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

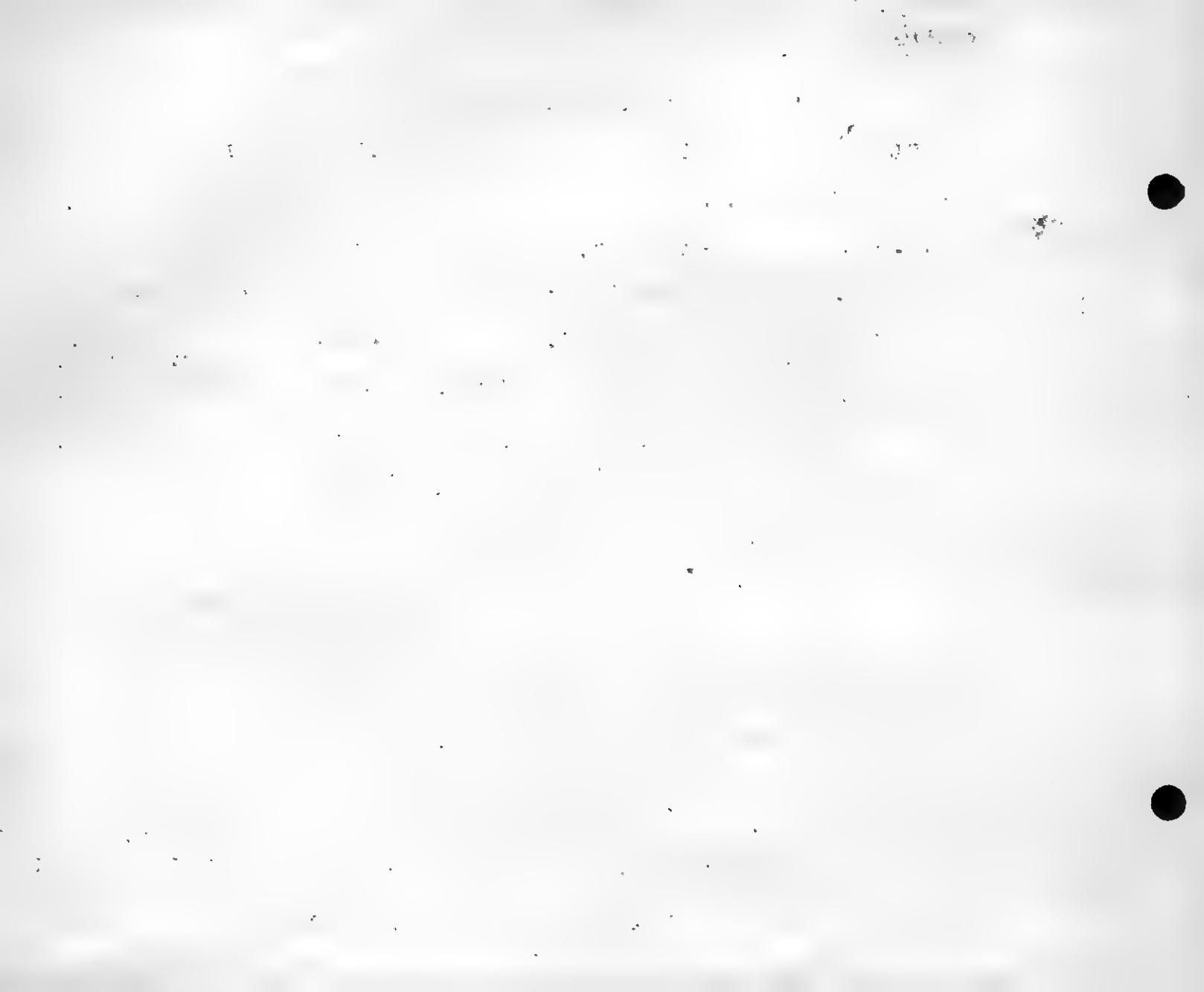
10167

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME: (Type or print)	First HELEN	Middle ELIZABETH	Last LONGENBERGER	2a. DATE OF DEATH Month AUG	Day 15	2b. HOUR 1968 3:20AM				
3. SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH JULY 14 1917		6. AGE (In years last birthday) 51		7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS DAYS 0	9. IF UNDER 24 HRS HOURS 0	10. IF UNDER 24 HRS MIN 0	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON				
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSP.				12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) HOMEMAKER				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 933 SECURITY ROAD						
14. FATHER'S NAME CHARLES	First CHARLES	Middle MOYER	Last SR.	15. MOTHER'S MAIDEN NAME FLORENCE	Middle REIFFENDIFER	Last HAGERSTOWN MD.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO (If yes give war or dates of service) NONE	17. INFORMANT ARTHUR D LONGENBERGER				922 SECURITY ROAD HAGERSTOWN MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>circumstances of the coronary c</i> <i>1830</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <i>abdominal cramps</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING If either, name medical examiner		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that (I) (We) attended the deceased from <i>July 31 1968</i> to <i>Aug 4, 1968</i> , that (I) (We) last saw the deceased alive on <i>July 31 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edson B Moody M.D.</i>		22c. DEGREE EDSON B MOODY M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED <i>Aug 3 1968</i>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 363 S CLEVELAND AVE HAGERSTOWN MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 8/4/68		23c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S LUTHERAN CEM.		23d. LOCATION (City or Town) RINGTON		(County) PENNA	(State)	
24. FUNERAL DIRECTOR <i>Charles B. Moody</i>		ADDRESS HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR DAUG 5 1968		25b. REGISTRAR'S SIGNATURE <i>Charles B. Moody</i>				



FOR STATE
HEALTH DEPT.any day of the month of **July**, in the year **1968**, at **12:00 PM**

12163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

178

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	10:25 AM		
Marvel				Major				8/25/68 19		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 HRS DAYS	9. IF UNDER 24 HRS HOURS	10. IF UNDER 24 HRS MIN.	10:25		
F	W	3/8/1947	21 YRS							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD Month 8/25/68 Day 19 Year 19		
MD.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington		2d. HOUR		
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington CO. Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BEAUTY BEAUTICIAN	12b. KIND OF BUSINESS OR INDUSTRY Beautician	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ND.				13c. CITY OR TOWN Allegany		13d. INSIDE CITY LIMITS Lonaconing		13e. STREET AND NUMBER Flordia Way		
14. FATHER'S NAME Dalton				15. MOTHER'S MAIDEN NAME Major				Shirley	Warnick	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Mrs. Shirley Major, Lonaconing, Md. (MOTHER)		ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fat embolus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several hrs
Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF (b) Fracture, femur, left.						
				DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION 8/24/68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Skin graft				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 4:45 PM 8/24/68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Auto-auto accident		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hiway				21f. LOCATION Street or R.F.D. No. City or Town State Rt. #36 at Gilmore, Alleghany, Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED 8/26/68
ACTUAL SIGNATURE 								CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Howard N. Weeks, M. D.								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
								ADDRESS (Street, city, town, or county) Moscow, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/28/1968		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery		23d. LOCATION (City or Town) Moscow, Md.		(County) (State)		
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.		25a. REC'D. BY REG. STAR Charles J. Judge		25b. REGISTRAR'S SIGNATURE Charles J. Judge		DATE AUG 30 1968		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the
funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS 100-1000
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

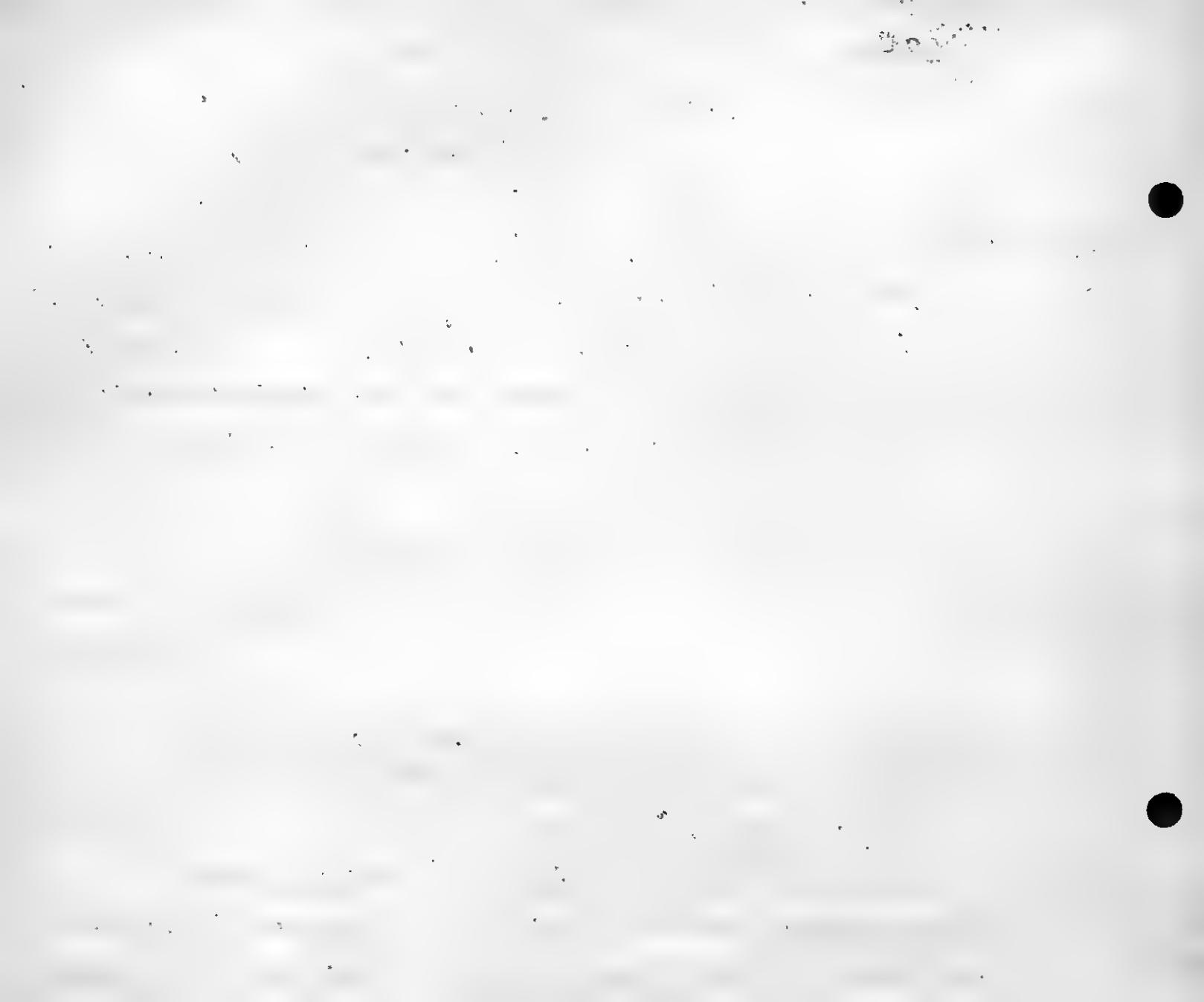
CERTIFICATE OF DEATH

19179

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH	2b. HOUR
John ABRAM Marshall			8	Month 23 Day 68 Year	7:10 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Male	White	7-24-1877		91 YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH	
Willis, Va.	U.S.A.	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Washington	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR IND.STRY
Boonsboro	Fairway Reedy Home		FARMER		OWN FARM
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MARYLAND	HOWARD	ELLIOTT CITY	YES <input checked="" type="checkbox"/>	40 DEERFIELD DRIVE	
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First
El.				Hannah	Wedge
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
NO	218-24-7595	MRS LEROY THOMPSON	ELLIOTT CITY MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease 5 years					
4129 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF					
lost. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Aug 5, 1968, to Aug 23, 1968, that (I) (we) last saw the deceased alive on Aug 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED-DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
G. W. LeVan M.D.		Boonsboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town) (County) (State)
FUNERAL		AUG 27-1968	PIPE CREEK		NEW WINDSOR, BORO OF MD
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
D. D. Hartzler & Sons, Union Bridge				DATE AUG 28 1968 Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

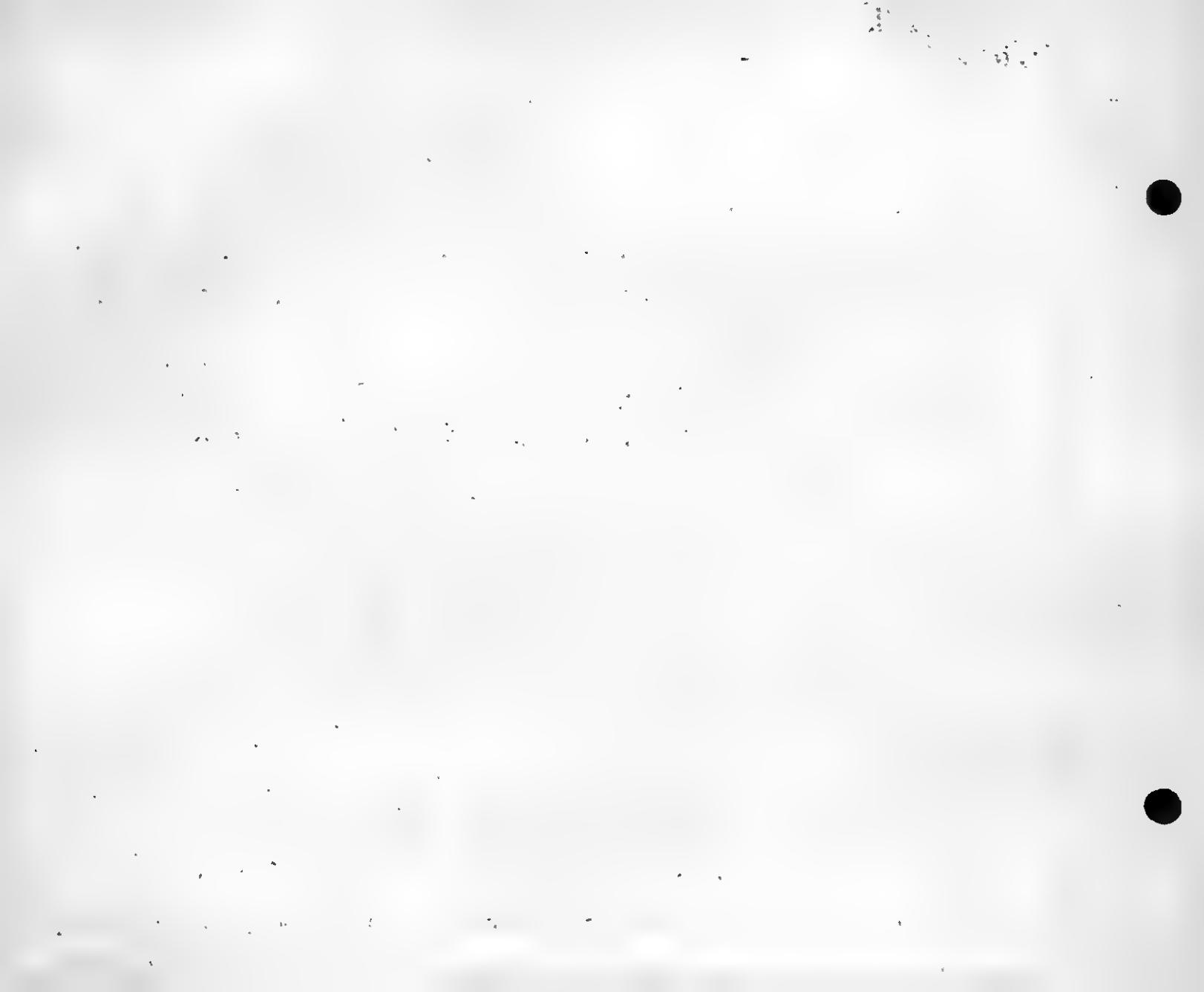
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First HARRY	Middle JAMES	Last McCARRAHER	2a. DATE OF DEATH Month AUGUST	Day 5	Year 68	2b. HOUR 9:30 A.M.		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 22, 1898		6. AGE (In years last birthday) 70	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN 0	
7a. BIRTHPLACE (State or foreign country) UNKNOWN	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON	10. CITY OR TOWN OF DEATH HAGERSTOWN					
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 92 W. WASHINGTON ST.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ELEVATOR OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY HOTEL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 92 W. WASHINGTON ST.					
14. FATHER'S NAME UNKNOWN	First UNKNOWN	Middle UNKNOWN	Last UNKNOWN	15. MOTHER'S MAIDEN NAME UNKNOWN	First UNKNOWN	Middle UNKNOWN	Last UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown UNKNOWN	16b. SOCIAL SECURITY NO. 579-01-3607	17. INFORMANT WILLIAM J DWYER	10 N Address JONATHAN ST.		10. Address HAGERSTOWN, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Dilation		DUE TO, OR AS A CONSEQUENCE OF Arterial Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause None		(b) DUE TO, OR AS A CONSEQUENCE OF Arterial Occlusion							
(c) None									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None									
19a. DATE OF OPERATION 4/20/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. 10 Month Aug Day 16 Year 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 1 May 1968 to Aug 16, 1968							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) None	21f. LOCATION Street or R.F.D. No. None	City or Town HAGERSTOWN		County MARYLAND		State M.D.		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 16, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W.H. Bechley		22c. DATE SIGNED Aug 12/68							
22d. PHYSICIAN'S NAME (Type) W.H. Bechley	D. AGREE 5	ATTENDING PHYS. W.H. Bechley	MED. DIRECTOR W.H. Bechley	STAFF PHYS. W.H. Bechley					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/8/68	23c. NAME OF CEMETERY OR CEMETORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) HAGERSTOWN	(County) WASHINGTON		(State) M.D.			
24. FUNERAL DIRECTOR Charles J. Judge	ADDRESS HAGERSTOWN, MARYLAND	25a. REC'D BY REGISTRAR Charles J. Judge	25b. REGISTRAR'S SIGNATURE Charles J. Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

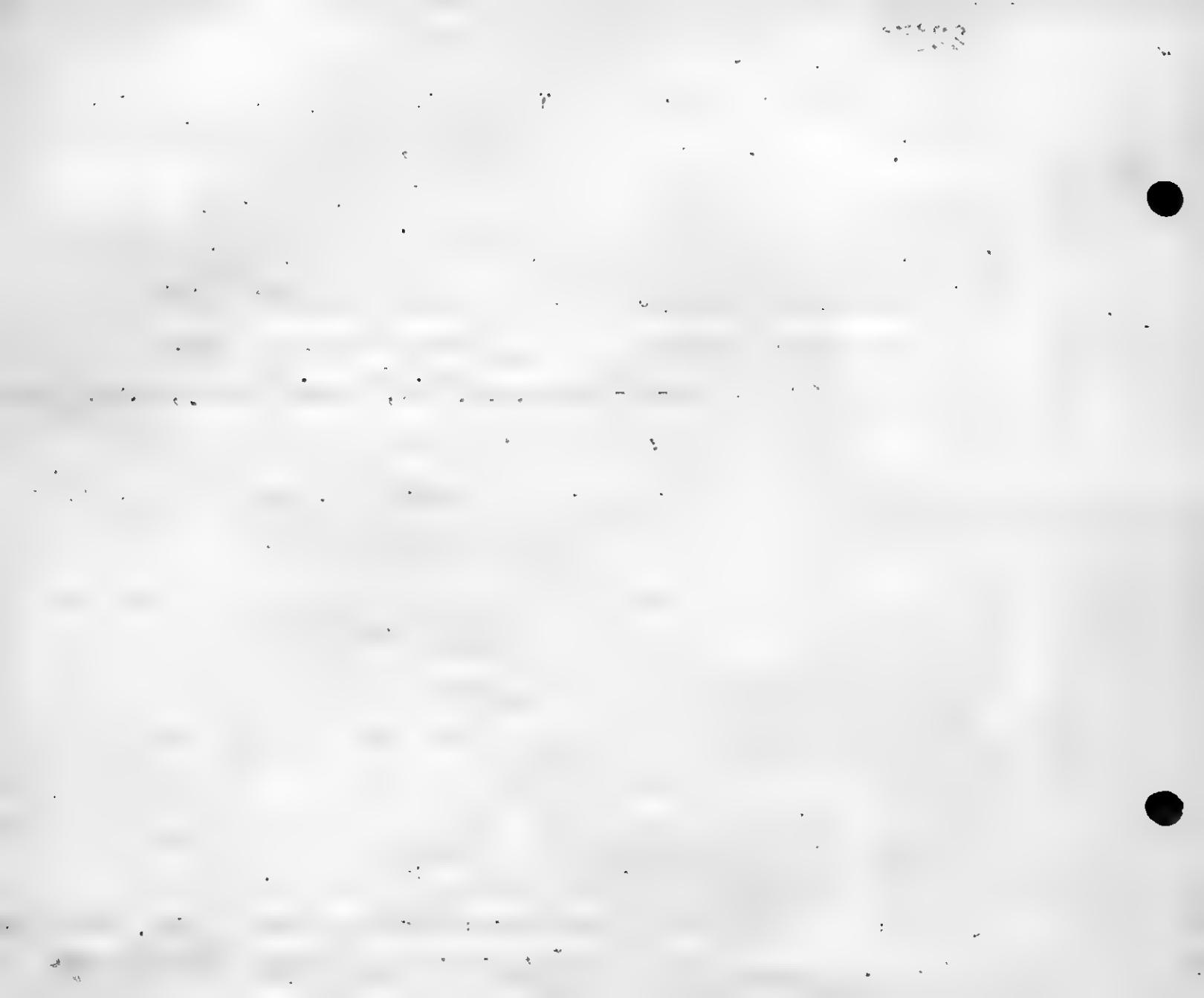
12171 CERTIFICATE OF DEATH

1181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Alvey Lee McGowan</i>	Middle <i></i>	Last <i></i>	2a. DATE OF DEATH Month Day <i>August 5 1968</i>	2b. HOUR <i></i>				
3. SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>June 19, 1901</i>		6. AGE (In years lost birthday) <i>67</i>	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS. DAYS <i></i>	IF UNDER 24 HRS. HOURS <i></i>	IF UNDER 24 HRS. MIN. <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Washington</i>						
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Stone</i>				
13a. U.S. RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Dargan</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>Shinham Road</i>					
14. FATHER'S NAME First <i>James Albert McGowan</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Katee Magdalene Pierce</i>	Middle <i></i>	Last <i></i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>None</i>	16c. INFORMANT <i>Mrs. Mary H. Gay</i>	Address <i>R.F.D. # 1, Harpers Ferry, W.Va. 25425</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac insufficiency</i>							<i>3 weeks</i>		
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year P.M. <input type="checkbox"/> 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 17, 1968</i> , to <i>Aug 5, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug 5, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Mary Gay M.D.</i>		22c. DATE SIGNED <i>Aug 6, 1968</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) <i>G. W. Lee Van</i>		22e. ADDRESS <i>Boonsboro</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Boonsboro</i>		23b. DATE <i>8/8/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Samples Manor Cemetery Harpers Ferry, W.Va. 25425</i>		23d. LOCATION (City or Town), (County), (State) <i>Samples Manor, Wash., Md.</i>				
24. FUNERAL DIRECTOR <i>Donald E. Cagle</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>Aug 8, 1968</i>			



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)	First <i>Daisy</i>	Middle <i>May</i>	Lost <i>Minnebraker</i>	2a. DATE OF DEATH Month <i>August</i>	Day <i>23</i>	Year <i>1968</i>	2b. HOUR <i>M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Sept. 9, 1882</i>		6. AGE (In years lost birthday) <i>85</i>	IF UNDER 1 YEAR MONTHS <i>YRS.</i>	IF UNDER 24 HRS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Clayton, Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH <i>Washington</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>R # 5 Herman Myers Road</i>			
14. FATHER'S NAME First <i>Emmanuel</i>	Middle <i>Matthias Coffman</i>	Lost <i>Annie May</i>	15. MOTHER'S MAIDEN NAME First <i>Mary</i>	Middle <i>Barton</i>	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOC. SECUR. NO (If yes give war or dates of service) <i>220-54-4911</i>	17. INFORMANT <i>Mr. John N. Minnebraker</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 weeks</i>				
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) <i>Nephrosclerosis</i> stating the underlying cause last. <i>445 X</i> (c) <i>arteriosclerosis</i> <i>Partial intestinal obstruction, atonic colon. Hypertension</i> years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Partial intestinal obstruction, atonic colon. Hypertension</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work at work	21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, Etc.)	21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>16 June 1952</i> date, that (I) (we) last saw the deceased alive on <i>27 Aug 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED <i>24 Aug 68</i>	
22b. SIGNATURE <i>Richard T. Binford</i>	DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) <i>Richard T. Binford, M.D.</i>	22e. ADDRESS <i>Hagerstown, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>8/26/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rest Haven Cemetery</i>	23d. LOCATION (City or Town) <i>Hagerstown-Washington-Md.</i>	(County) <i></i>	(State) <i></i>		
24. FUNERAL DIRECTOR <i>Wm. C. Best</i>	ADDRESS <i>Rest Haven Funeral Chapel</i>	25a. REC'D BY REG. STRR. <i>AUG 26 1968</i>	25b. REG. STRR'S SIGNATURE <i>Charles Juge</i>				

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18174

CERTIFICATE OF DEATH

184

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Frederick	Middle Clinton	Last Mongan	2a. DATE OF DEATH Month August	Day 7	Year 1968	2b. HOUR 8:30 P.M.		
3. SEX male	4 RACE white	5. DATE OF BIRTH 12-7-1896		6. AGE (In years lost birthday) 71	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS DAYS 0	9. IF UNDER 24 HRS HOURS 0	10. IF UNDER 24 HRS MIN 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 911 Spruce, St.		12a. USUAL OCCUPATION (Kind of work done during most working life, even if retired) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Steel Fabrication				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Wash. Hagerstown	13c. CITY OR TOWN Wash. Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 911 Spruce, St.					
14. FATHER'S NAME Clinton Mongan	15. MOTHER'S MAIDEN NAME E Stella Mongan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO 214-09-3279	17. INFORMANT Mrs. Katherine Mongan	Address Hagerstown, Md.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15-20 mins		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion									
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201									
DUE TO, OR AS A CONSEQUENCE OF Hypertensive and Atherosclerotic Heart									
(b) Disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pulmonary Emphysema; Chronic Bronchitis; Hydrocele Right.									
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. 19 Month Aug Day 7 Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 100 Prof Arts Bldg.	City or Town Hagerstown, Md.	County 21740	State				
22a. I certify that (I) (this hospital) attended the deceased from March 15 , 19 68 , to Aug 7 , 19 68 , that (I) (we) last saw the deceased alive on Aug 7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. D. Layman, M.D.									
22c. DEGREE PHYS	ATTENDING PHYS	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Aug 9 1968					
22d. PHYSICIAN'S NAME (Type) William D. Layman, M.D.	22e. ADDRESS 100 Prof Arts Bldg. Hagerstown, Md. 21740								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-10-68	23c. NAME OF CEMETERY OR CEMINATORY Rest Haven Cemetery	23d. LOCATION (City or Town) Hagerstown, Md.	(County)	(State)				
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.	ADDRESS	25a. REC'D. BY REGISTRAR DATE AUG 12 1968	25b. REGISTRAR'S SIGNATURE Charles Judge						



FOR STATE
HEALTH DEPT
W

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
18175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First Middle Last
CHARLES CLINTON MURRAY

2. DATE KNOWN Month Day Year 1968 8 P.M.
OF ESTI-
MATED

3. SEX Male RACE White DATE OF BIRTH March 26 1893 AGE (in years) 75
IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
LAST BIRTH 75 YRS

4. DATE PRONOUNCED DEAD Month Day Year Aug 14 1968 11:40 A.M.
2d HOUR

5. BIRTHPLACE (State or foreign country) Maryland CITIZEN OF WHAT COUNTRY? Washington
6. MARRIED NEVER MARRIED 7. WIDOWED DIVORCED 9. COUNTY OF DEATH Washington

10. CITY OR TOWN OF DEATH Hagerstown 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Sharpsburg Pike 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer 12b. KIND OF BUSINESS OR INDUSTRY --

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN RFD 13d. INSIDE CITY LIMITS? YES NO 13e. STREET AND NUMBER Sharpsburg Pike

14. FATHER'S NAME First Middle Last 15. MOTHER'S MAIDEN NAME First Middle Last
Harry David Murray **Emma C. McLaughlin**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16b. SOCIAL SECURITY NO. 16c. INFORMANT ADDRESS
(If you give name or date of service) **W.H. #1** **217-32-7011** **Daniel Murray** **Clear Spring Md R #1**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Coronary occlusion* APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Tumour
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) *Arterio sclerotic vascular disease* 25 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c) *+ Arterio's clausis heart & disease*

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
Past life hypertension, benign

19a. DATE OF OPERATION 19b. CONDITON FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?
 YES NO

21a. MEDICAL CERTIFICATION
21b. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING 21c. TIME OF INJURY Month, Day Year
CAUSE OF DEATH P.M. 19
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 21f. LOCATION Street or R.F.D. No. City or Town County State

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE *Edward W. Ditto, III* M.D. 22b. DATE SIGNED *8-14-68*

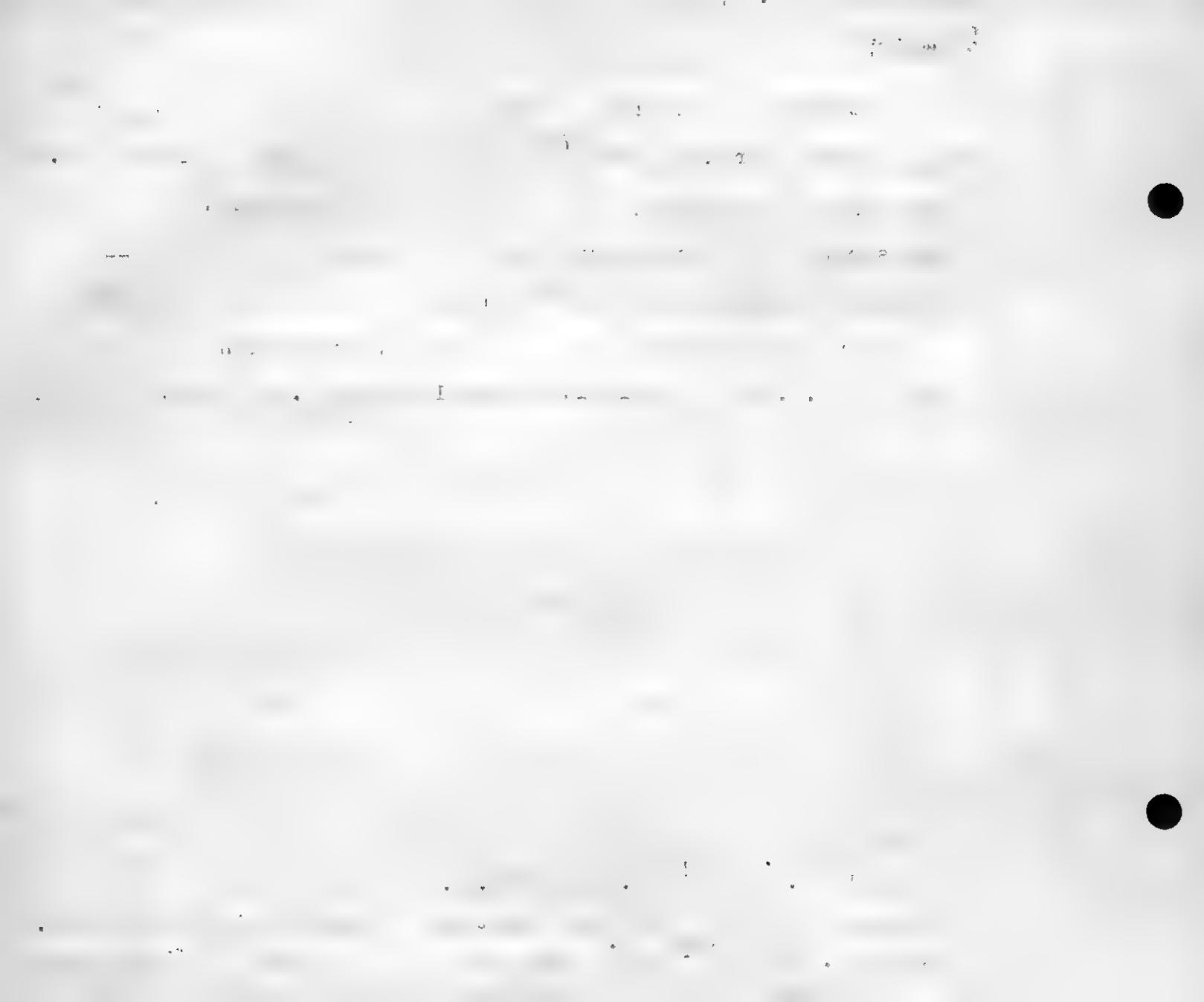
EXAMINER'S NAME (Type) **Edward W. Ditto, III**
217 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORIAL BROADFORDING WASH CO MD.
Burial **8/15/68** **Dunkard Cemetery** **Broadfording Wash Co Md.**

24. FUNERAL DIRECTOR HAGERSTOWN MD ADDRESS **Andrew K. Coffman Funeral Home Inc**

25a. REC'D. BY REG. STRR. 25b. REGISTRAR'S SIGNATURE
DATE **AUG 16 1968** *James J. Gage*

VR A15ME (5)
10M REV. 1/68



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign page 2 and 3. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR M		
CARRIE FAYE NICODEMUS			August 23 1968				
3. SEX Female	4 RACE White	5. DATE OF BIRTH 1882 Dec. 30 1885		6. AGE (in years lost birthday) 85 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Penns	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. L.S.J.A.L. RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 124 East Ave			
14. FATHER'S NAME Alfonso L. Nicodemus	First	Middle	Last	15. MOTHER'S MAIDEN NAME Dora Morgal			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO --	17. INFORMANT Ralph M. Nicodemus 36 East Ave			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 41. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Hagerstown Md. myocardial infarction Cateresebrile heart disease				
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No	City or Town	County	State
22a. I certify that (s) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (s) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death							
22b. SIGNATURE Jean Nicodemus				22c. DATE SIGNED 22d. ADDRESS FRANCIS E. ROSILLI 530 Northern Ave. Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/26/68	23c. NAME OF CEMETERY OR CREMATORIUM Green Hill Cemetery		23d. LOCATION (City or Town) Waynesboro	(County) Franklin	(State) Pa
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR DATE AUG 27 1968	25b. REGISTRAR'S SIGNATURE jCharles Judge		

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove can in papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Wilhelmenia Julia	Nikel			Aug	22	1968	11:35 AM
3. SEX	4 RACE			5. DATE OF BIRTH			
7	W			Dec 11 1886	8-1 YRS		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH				
Richmond	USA		Washington				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY				
Williamsport	Holmeswood Church	Home	Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Va	None	Richmond	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	503 N. Lombardy St.			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
Frederick Otto Heifet				Amalie			Dietrich
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address				
No	230-70-4055	Mark Waggoner	2750 1/4 Ave Wright, Md.				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
1 week							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) Coronary (C. claudio) DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause							
(b) Hypertensive Disease DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
420: General Circumstances							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or RFD No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 1-11, 1967 to 8-22, 1968, that (I) (we) last saw the deceased alive on 1-11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did-not) view the body after death.							
22b. SIGNATURE		DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS	22c. DATE SIGNED	
Robert J. Coffey, M.D.			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8-22-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23d. LOCATION (City or Town) (County) (State)			
Robert J. Coffey, M.D.		3740 Frostington Hagerstown, Md.		Richmond Virginia			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City or Town)	(County)	(State)	
Burial		8-24-68	Oakwood Cemetery	Richmond			
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Daguerstowm		Andrew K Coffey Funeral Home Inc	AUG 29 1968	Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12173

CERTIFICATE OF DEATH

4 2 4 88

1. DECEASED-NAME (Type or print)			First ETHEL	Middle SARAH	Last RAFUS	2a. DATE OF DEATH Month AUGUST	Day 18	Year 68	2b. HOUR 2:40 P.M.
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 25, 1906		6. AGE (in years last birthday) 61		IF UNDER 1 YEAR MONTHS YRS.	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH WASHINGTON		10. CITY OR TOWN OF DEATH HAGERSTOWN	
11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) HOUSEKEEPER HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME					
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1440 HAMILTON BLVD.			
14. FATHER'S NAME First CLARENCE		Middle T	Lost PRaul	15. MOTHER'S MAIDEN NAME First CORA		Middle UNKNOWN		Lost 	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 219-28-4879		17. INFORMANT HENRY W. RAFUS		1440 HAGERSTOWN, MARYLAND		Address HAMILTON BLVD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mo	
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of rectum									
DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1530									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) <input type="checkbox"/> attended the deceased from JUN 2, 1968 to AUG 18, 1968 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on Aug 17 1968 , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE Lloyd A. Hoffman		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 8/19/68			
22d. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN, M.D.		22e. ADDRESS 214 N. POTOMAC ST., HAGERSTOWN, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8/20/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS REST HAVEN CEMETERY HAGERSTOWN, MARYLAND		23d. LOCATION (City or Town) HAGERSTOWN WASHINGTON		(County) MD.	(State)
24. FUNERAL DIRECTOR Charles George				25a. REC'D BY REGISTRAR AUG 21 1968		25b. REGISTRAR'S SIGNATURE Charles George			

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. **Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any eight, within 72 hours after death.**



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12179 CERTIFICATE OF DEATH 189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First OSCAR	Middle JOB	Last RASH	2a. DATE OF DEATH Month AUGUST	Day 11	Year 1968	2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MAY 24, 1885			6. AGE (in years last birthday) 83	7. IF UNDER 1 YEAR MONTHS YRS	8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON			
10. CITY OR TOWN OF DEATH HANCOCK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) 15 E. MAIN STREET			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) B&O RAILROAD TELEGRAPH OP.			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HANCOCK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 15 E. MAIN STREET			
14. FATHER'S NAME First WILLIAM	Middle G.	Last RASH	15. MOTHER'S MAIDEN NAME First ANGELA	Middle MANN	Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 705 05 8013	17. INFORMANT ELSIE H. RASH	Address 15 E. MAIN ST. HANCOCK			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary occlusion +109 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> stating the <u>underlying cause</u> (b) ASHD + Passive Heart Failure DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) +1							
19a. DATE OF OPERATION 1/1/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 4/7/63 , 19 19 , to 8/11/68 , 19 19 , that (I) (we) last saw the deceased alive on 6/23/68 , 19 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 8/12/68	
22b. SIGNATURE FB Thomas III MD	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	<input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) Frank B. Thomas III MD	22e. ADDRESS Hancock, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/13/68	23c. NAME OF CEMETERY OR CREMATORIAL PRESBYTERIAN CEMETERY	23d. LOCATION (City or Town) WARFORDSBURG FULTON PA.	(County)	(State)		
24. FUNERAL DIRECTOR ADDRESS Howard & Gene Hancock, md	25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			
DATE AUG 15 1968							

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12180 CERTIFICATE OF DEATH

1110

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Homer	Middle Leon	Lost Reed	2a. DATE OF DEATH Month August	Day 6	Year 1968	2b. HOUR 10:21 P M	
3 SEX Male	4 RACE White	5. DATE OF BIRTH March 4, 1926		6 AGE (in years last birthday) 42	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS DAYS	9 IF UNDER 24 HRS HOURS	
7a. BIRTHPLACE (State or foreign country) Big Pool Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		Md.			
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Capt. of York		12b. KIND OF BUSINESS OR INDUSTRY Prison			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Keedysville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 48 Main St.				
14 FATHER'S NAME Jesse	First Middle Reed	15. MOTHER'S MAIDEN NAME First Margaret	Middle	Last Gladhill				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. W. W. 10 220-18-3121	17 INFORMANT Mrs. Catherine E. Reed	Address 48 Main St., Keedysville		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 144 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
42-1		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>Aug 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Edson B. Moody</u> DEGREE ATTENDING PHYS MED DIRECTOR STAFF PHYS								
22c. DATE SIGNED <u>Aug 8, 1968</u>								
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 8-10-68	23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery	23d. LOCATION (City or Town) Keedysville	(County) Wash. Co., Md.	(State)			
24. FUNERAL DIRECTOR John H. Baet, Jr.	ADDRESS 112 N. Main St. Roonsboro, Md.		25a. REC'D. BY REGISTRAR AUG 12 1968	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>				



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNE Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)

12181

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 22, 29, 31, 33, 38, 42, 48, 52
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1

1218 1219

1. DECEASED NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR		
Howard		Marshall	Ridenour						Aug. 10 1968 5:30 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR	8. UNDER 24 HRS						
Male	White	Sept. 14, 03	64	MONTHS YRS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD Month Day Year			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			2d. HOUR		
Maryland		U.S.A.		W DIVORCED <input type="checkbox"/>		Washington			Aug. 10 1968 7:15 P.M.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. JSJA. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Washington County				Trackman			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMIT?			13e. STREET AND NUMBER		
Maryland		Washington		Big Pool		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD-1		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Joseph				Ridenour	Sara Reed						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS					
No		705-10-5749		Rosalie Ridenour		BigPool, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Coronary, occlusion</u> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <u>time</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>by her fiancee Carlita Vassar</u> 200g											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>drugs</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1b)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward W. Ditto, III, M.D.</u> M.D.											
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town)		(County)		(State)	
Burial		Aug. 14, 68		Park Head Cemetery		Park Head Wash. Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Donald Thompson											
Thompson Funeral Home Clear Spring, Md. DATE AUG 15 1968											

FOR STATE
HEALTH DEPT.

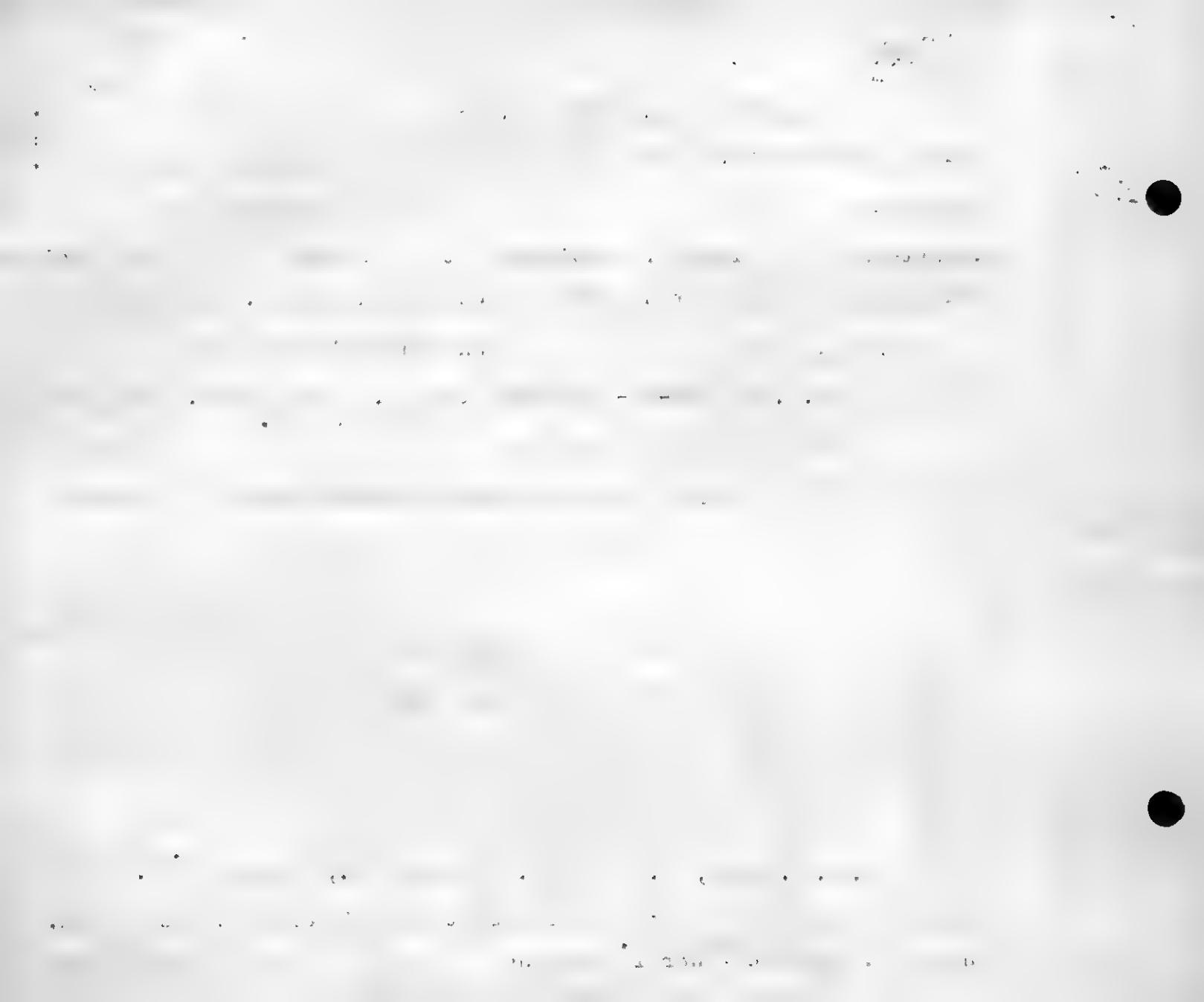
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm P.M. 3. Page M. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12182 12192

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month Aug 23 1968	Day 19	Year 1968	8 HOUR A. M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Aug 23 1968			24 HOUR A. M
Male	White	May 29 1899	69 yrs						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1839 W. Washington St.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Plumber			12b. KIND OF BUSINESS OR INDUSTRY Own Business	
13a. USUAL RESIDENCE (Where deceased lived, institution Residence before address on) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 1839 W. Washington St				
14. FATHER'S NAME Frank R. Roof		First	Middle	Lost	15. MOTHER'S MAIDEN NAME Anna Kate Eichelberger	First	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO W.W.#1 214-09-1578		17. INFORMANT Mrs. Olive T. Roof	18. ADDRESS 1839 W. Washington St Hagerstown Md.			APPROX. TIME INTERVAL BETWEEN ONSET AND DEATH Instant	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <u>Arteriosclerotic Cardiac Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)					5 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Dr. E. W. Ditte, Jr.</i>		22b. DATE SIGNED M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Aug. 24, 1968							
EXAMINER'S NAME (Type) Dr. E. W. Ditte, Jr.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE 8/26/68		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION (City or Town) Hagerstown Wash Co Md.			(County) (State)	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR Hagerstown Md. ADDRESS			25b. REGISTRAR'S SIGNATURE DATE AUG 27 1968 <i>Charles Judge</i>				
VR A15ME (5) 10M REV 1/68									



12183

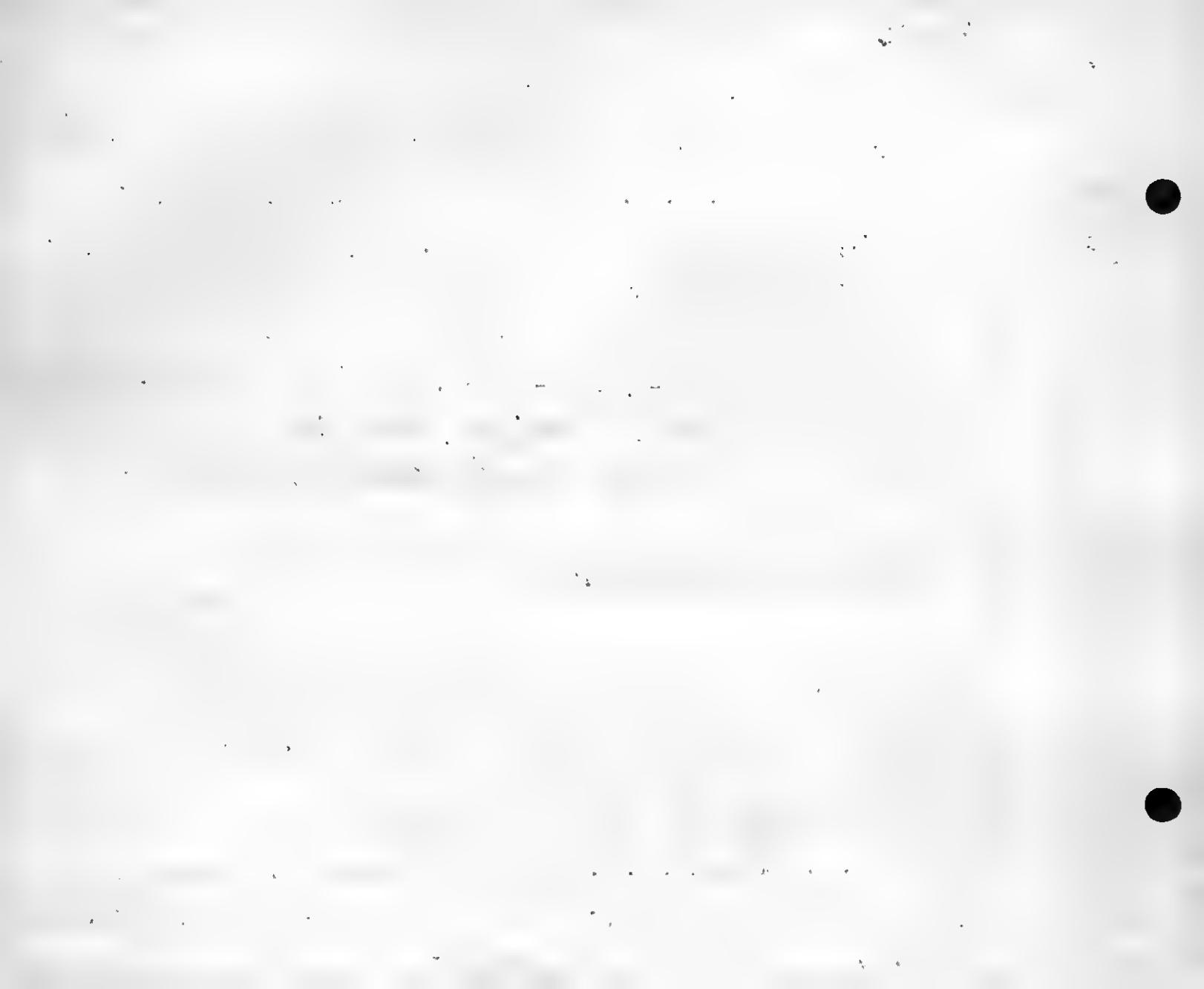
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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First TONY	Middle JOSEPH	Last SCALESE	2a. DATE OF DEATH AUGUST 22, 1968	2b. HOUR 9:10 PM		
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH APRIL 1, 1898		6. AGE (In years last birthday) 70 yrs.	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNA.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON COUNTY		Md		
10. CITY OR TOWN OF DEATH HAGERSTOWN, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHIN GTON CO. HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) RETIRED GROCER		12b. KIND OF BUSINESS OR INDUSTRY GROCERY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN SMITHSBURG	13d. INSIDE CITY J.M.T.S? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER Rt #3			
14. FATHER'S NAME JOSEPH	First Middle SCALESE	Last ROSE	15. MOTHER'S MAIDEN NAME MIRRELLA	Middle ROSE	Last Rt #3		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input type="checkbox"/> NO	16b. SOCIAL SECURITY NO. 175-18-8974-A	17. INFORMANT MRS. CATHERINE M. SCALESE	Address SMHBG, MD.				
18. CAUSE OF DEATH (Enter any one cause per line) (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary thrombosis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>osteoarthritis of heart disease</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>medicai</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7. <i>Diabetes mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____				
22a. I certify that (I) (this hospital) attended the deceased from <u>7-2-68, 19</u> to <u>8-22, 1968</u> , that (I) (we) last saw the deceased alive on <u>8-15 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John de la H</i>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 8/23/68		
22d. PHYSICIAN'S NAME (Type) E. R. Lardizabal, M. D.		22e. ADDRESS 300 N. Potomac St. Hagerstown, Md.					
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE AUG 26, 1968	23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEMETERY	23d. LOCATION (City or Town) HAGERSTOWN	(County) WASH CO., MD.	(State)	
24. FUNERAL DIRECTOR <i>W.T. Neumann</i>		ADDRESS ST. S Hagerstown	25a. REC'D BY REGISTRAR DATE AUG 27 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>John</i>	Middle <i>William</i>	Last <i>Shifflet</i>	2a. DATE OF DEATH Month <i>August</i>	Day <i>7</i>	Year <i>1968</i>	2b. HOUR <i>8:10 A.M.</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>August 14, 1898</i>		6. AGE (in years last birthday) <i>69</i>		7. IF UNDER 1 YEAR MONTHS <i>0</i>	8. IF UNDER 24 HRS MONTHS <i>0</i>	9. IF UNDER 24 MINS HOURS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Singers Glen, Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Washington</i>		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Barber</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Barber Shop</i>		
13a. USUAL RESIDENCE (Where deceased lived, if inst. t. an admission) <i>Maryland</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>641 W. Washington St.</i>		
14. FATHER'S NAME First <i>David</i>		Middle <i>Price</i>	Last <i>Shifflet</i>	15. MOTHER'S MAIDEN NAME First <i>Lavinia</i>		Middle <i>Shaeffer</i>	Address <i>Hagerstown, Md.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <i>772-12-3032</i>		17. INFORMANT <i>Mrs. Catherine Blickenstaff</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i> (Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>4109</i>) DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4101</i>								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>2/2</i> , 1961, to <i>8/7</i> , 1968, that (I) (we) last saw the deceased alive on <i>8/7</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE <i>George Jennings M.D.</i>		22c. DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22d. DATE SIGNED <i>8/9/68</i>			
22e. PHYSICIAN'S NAME (Type) <i>George Jennings</i>		22f. ADDRESS <i>318 N. Poplar St. Hagerstown, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8/10/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) <i>Hagerstown-Washington Md.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Wm. C. Stroob</i>		ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
DATE <i>AUG 13 1968</i>								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First MARY	Middle ELIZABETH	Last SHIPLEY	2a. DATE OF DEATH Month Aug. Day 30 Year 1968	2b. HOUR M		
3. SEX Female	4 RACE White	5. DATE OF BIRTH Sept. 25 1886		6. AGE (In years last birthday) 81 YRS.	F UNDER 1 YEAR 11 MONTHS	IF UNDER 24 HRS. 5 DAYS	IF UNDER 24 HRS. 0 HOURS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington County			
10. CITY OR TOWN OF DEATH Williamsport	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital - give street address) 124 W. Salisbury St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Williamsport	13d. INSIDE C.TY. J.M.T.P. X	13e. STREET AND NUMBER 124 W. Salisbury St.			
14. FATHER'S NAME First Nathaniel	Middle Hunter	Last Turner	S. MOTHER'S MAIDEN NAME First Sarah	Middle Elizabeth	Last Rideneur		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO NO	17. INFORMANT Mrs. Kenneth Schreyer	Address 2707 Buford Dr. Williamsport Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7100 (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause) Coronary artery occlusion with Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
(b) Coronary artery atherosclerosis				unknown			
(c) Hypertensive arteriosclerotic heart Disease				12 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus							
19a. DATE OF OPERATION =====	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED Not while at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 04/09/56 , 19, to 08/30/68 , 19, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 08/09/68 , 19, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> view the body after death						22c. DATE SIGNED Aug. 31, 1968	
22b. SIGNATURE <i>Archie Robert Cohen, M.D.</i>	22c. DEGREE M.D.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.	22e. ADDRESS Clear Spring, Maryland						
23a. BURIAL, CREMATION, BURIAL SITE(S) BURIAL	23b. DATE Sept. 2-68	23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery	23d. LOCATION (City or Town) Williamsport	(County) Wash. Md.	(State)		
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.	ADDRESS	25a. REC'D BY REGISTRAR SFP	25b. REGISTRAR'S SIGNATURE 3 1968				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
18185 CERTIFICATE OF DEATH

2136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR 5:30P
CLAUDE WILLIAM ANDREW SHIVES						
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 17, 1900		6. AGE (In years last birthday) 68	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HANCOCK	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 150 W. MAIN ST.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TAXI DRIVER	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HANCOCK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 150 W. MAIN STREET		
14. FATHER'S NAME First NOT KNOWN	Middle	Lost	15. MOTHER'S MAIDEN NAME First KATE	Middle	Lost SHIVES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-09-9355A	17. INFORMANT ELSIE M. SHIVES 150 W. MAIN ST.	Address HANCOCK, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause arteriosclerosis, lysis lost.						
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) None						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) 8/16/68		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No 816	City or Town HANCOCK	County MARYLAND
22a. I certify that (I) (this hospital) attended the deceased from 8/16/68 to 8/18/68 , that (I) (we) last saw the deceased alive on 8/16/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE W. M. Shaffer		DEGREE M. SHaffer MD.	ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 8/20/68	
22d. PHYSICIAN'S NAME (Type) M. SHaffer MD.		22e. ADDRESS HANCOCK, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/21/68	23c. NAME OF CEMETERY OR CREMATORIAL REHOBETH METHODIST		23d. LOCATION (City or Town) HANCOCK	(County) FULTON, PA.	(State)
24. FUNERAL DIRECTOR Howard & George Hancock md	ADDRESS		25a. RECD BY REGISTRAR Charles J. George	25b. REGISTRAR'S SIGNATURE		
		DATE AUG 23 1968				

$$M_1 \times \dots \times M_k \times \mathbb{C}^n \times \mathbb{P}^{k+1} \times \dots \times \mathbb{P}^n$$

1. *Leucosia* *leucosia* (L.) *leucosia* (L.) *leucosia* (L.) *leucosia* (L.)

19. *U. S. Fish Commission, Annual Report, 1881*, p. 111.

1. *What is the primary purpose of the study?*

11. *What is the primary purpose of the U.S. Constitution?*

11. *What is the primary purpose of the following sentence?*

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19187 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

197

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN IF ESTI- DEATH MATED	Month	Day	68	2b HOUR 12:10 A.M.	
Waneta Lucille Sigler						<input checked="" type="checkbox"/> Aug. 12, 1968					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	MONTHS	DAYS	MIN			
female	white	2-1-20	48								
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED	NEVER MARRIED	<input type="checkbox"/>	9 COUNTY OF DEATH				
Md.		USA		W DOWED	DIVORCED	<input type="checkbox"/>	Washington				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			2 Park Ave.			clerk			dry cleaners		
13a USUAL RESIDENCE (Where deceased lived, institution Residence before admission) STATE			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
Md.			Wash.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2 Park Ave.		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Clarence Cramer						Leah Grumbine					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
no						Chester R. Sigler Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Ruptured Congenital Aneurysm Of Left Vertebral Artery.</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause most											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Instant											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward W. Ditto, Jr., M.D.</u> M.D.											
EXAMINER'S NAME (Type) <u>Edward W. Ditto, Jr., M.D.</u>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22b. DATE SIGNED 8-13-68											
ADDRESS (Street, city, town, or county) <u>25 W. Washington St. Hagerstown, Maryland</u>											
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 8-14-68			23c NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d LOCATION (City or Town) (County) (State) Hagerstown, Md.		
burial											
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR DATE AUG 16 1968			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
Minnich Funeral Home Hagerstown, Md.											



12188

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Woodrow	Middle Wilson	Last Slonaker	2a. DATE OF DEATH Month Aug.	2b. HOUR Year 1968 9:40
3. SEX Male	4 RACE White	5. DATE OF BIRTH 3/3/13		6. AGE (in years last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) carpenter		12b. KIND OF BUSINESS OR INDUSTRY Walters Lane
13a. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. CITY OR TOWN Fostervile	13c. INSIDE CTY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4450/Walters Lane		
14. FATHER'S NAME James	Middle Slonaker	15. MOTHER'S MAIDEN NAME Florence Orndorff	Address Records, Western Md State Hospital		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 228-16-5498	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolus bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause) Thrombophlebitis, left leg and right leg DUE TO, OR AS A CONSEQUENCE OF last <u>463X</u> (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension arteriosclerotic cardiovascular heart disease & diabetes mellitus					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <u>4/16/68</u> , 19 <u>68</u> , to <u>8/26</u> , 19 <u>68</u> , that (I) <input type="checkbox"/> (we) last saw the deceased alive on <u>Aug. 26</u> 19 <u>68</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <u>Chong Choon Han</u>	M.D. DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED 8/26/68	
22d. PHYSICIAN'S NAME (Type) Chong C. Han, M.D.	22e. ADDRESS Western Md. State Hospital 1500 Pennsylvania Ave., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/29/68	23c. NAME OF CEMETERY OR CREMATORIAL Quaker Cemetery	23d. LOCATION (City or Town) CaponBridge	(County) Hampshire	(State) W Va
24. FUNERAL DIRECTOR John Clark	ADDRESS Giffin Funeral Home	25a. REC'D BY REGISTRAR DATE SEP 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12182 CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Mary	Middle D.	Lost Smith	2a. DATE OF DEATH Month August 18 Year 1968	2b. HOUR P 5:45 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH January 19, 1907		6. AGE (in years lost birthday) 61 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON	Md
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased tried, if institution admission) STATE Maryland	13c. CITY OR TOWN Frostburg	13d. INS. IN CITY LHM.152 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 58 Meshack Frost Village		
14. FATHER'S NAME William	Middle Dohme	15. MOTHER'S MAIDEN NAME Ada	Middle Berry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 219-11-7140	17. INFORMANT William S. Smith, Cleveland, Md. (SON)	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary occlusion, acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 43-1 <u>Diabetes mellitus</u>				20 years	
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1968</u> , to <u>August 18, 1968</u> , that (I) (we) last saw the deceased alive on <u>August 18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Fe U. Porciuncula M.D.</u>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8/19/68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/20/1968	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) Cumberland	(County) Alle.	(State) MD.
24. FUNERAL DIRECTOR George Eichhorn	ADDRESS Lonaconing, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10190

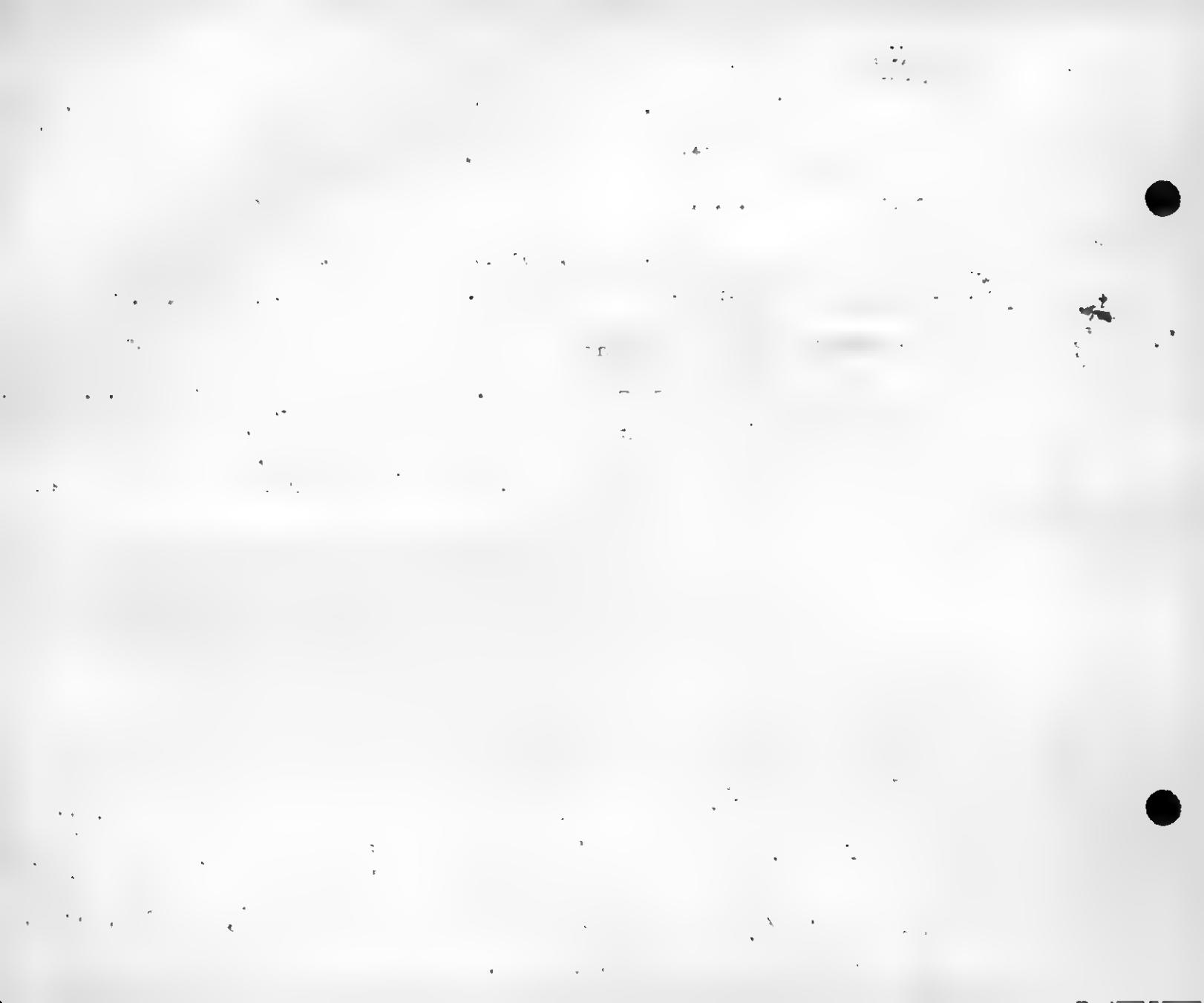
CERTIFICATE OF DEATH

22001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Carrie	Middle L.	Lost Snurr	2a. DATE OF DEATH Month Aug Day 19 Year 1968	2b. HOUR 9:30 AM
3. SEX Female	4 RACE White	5. DATE OF BIRTH Dec. 9, 1885		6. AGE (in years last birthday) 82	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Leitersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Hagerstown R. D. 5	
14. FATHER'S NAME First William	Middle Shank	15. MOTHER'S MAIDEN NAME Mary	Middle	Lost	Huffer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? no	16b. SOCIAL SECURITY NO. 220-34-1149D	17. INFORMANT Mrs. Howard Hartle	Address Hagerstown R.D. 5, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>large 2 M's heart failure</i> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause (b) <i>6/28/68 heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Heart Disease</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12:00					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or RFD No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <i>10/14/68</i> , to <i>8/19/68</i> , that (I) (we) last saw the deceased alive on <i>10/14/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. Howard Hartle</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>8/28/68</i>
22d. PHYSICIAN'S NAME (Type) <i>W. Howard Hartle</i>		22e. ADDRESS <i>313 W. Polk Street, Hagerstown, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE 8/22/1968	23c. NAME OF CEMETERY OR CREMATORIAL Green Hill	23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin, Penna.	
24. FUNERAL DIRECTOR <i>Walter G. Cox</i>		ADDRESS Waynesboro, Penna.	25a. REC'D BY REGISTRAR DATE AUG 23 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

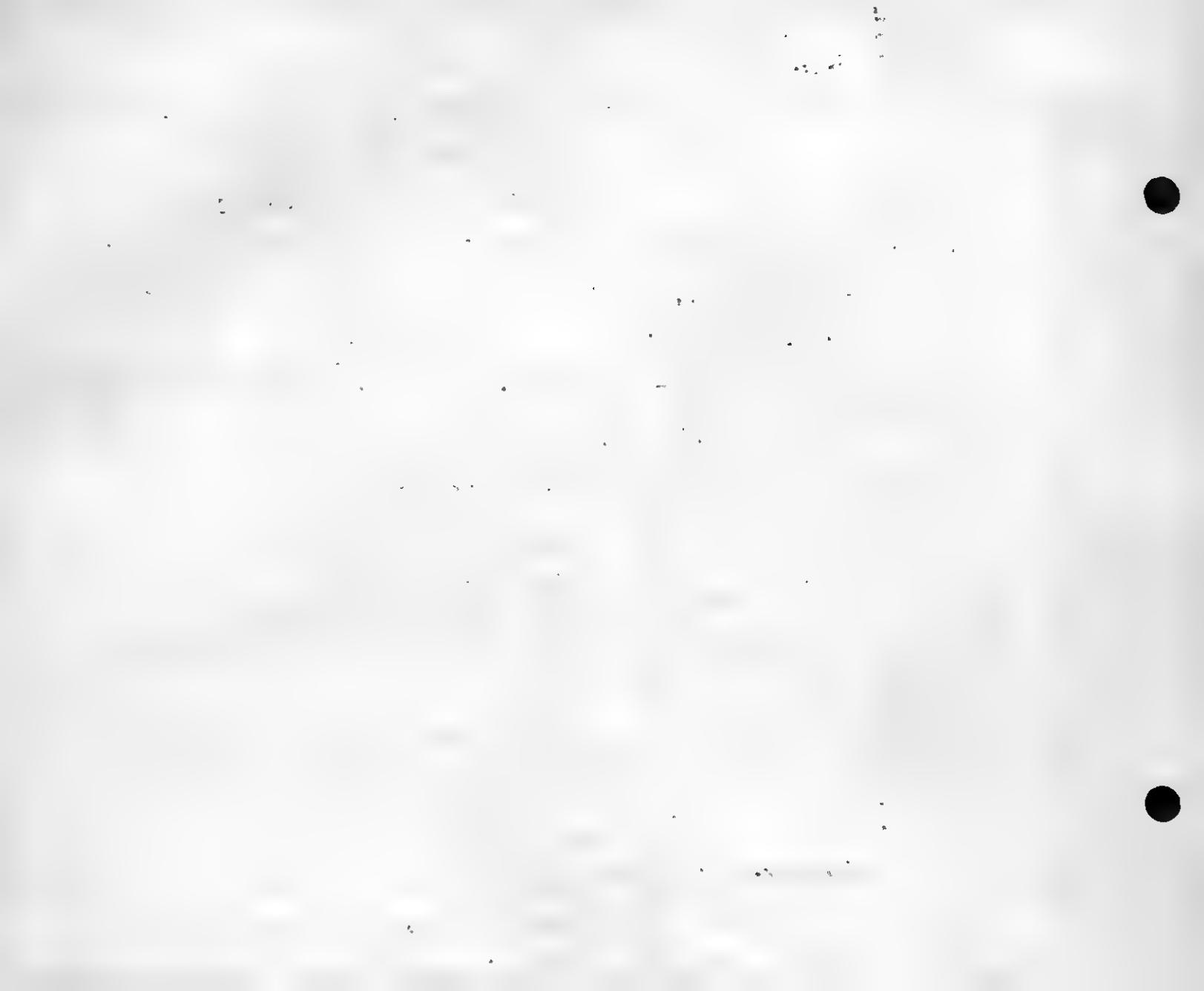
12191

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)	First Ezra	Middle Earl	Last Spielman	2a. DATE OF DEATH Month August	Day 19	Year 1968	2b. HOUR 1:45 P.M.					
3. SEX male	4. RACE white	5. DATE OF BIRTH 12-6-1890			6. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington							
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret'd) General work			12b. KIND OF BUSINESS OR INDUSTRY Dairy					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 101 Roesner, Ave.								
14. FATHER'S NAME Charles E. Spielman	First	Middle	Last	15. MOTHER'S MAIDEN NAME Emma Danner	First	Middle	Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown)	16b. SOCIAL SECURITY NO. 220-28-8231			17. INFORMANT Mr. Donald R. Spielman	Address Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic Cessus</i> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>old age</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arterioscleris heart disease</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Donald R. Spielman</i>									DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8/21/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS W. Wilson O. Rexford 410 145 S. Rooster St. Hagerstown, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-22-1968		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery			23d. LOCATION (City or Town) Hagerstown		(County) Wash. Md.		(State)	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS			25a. REC'D BY REGISTRAR DATE AUG 23 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Minnich</i>					



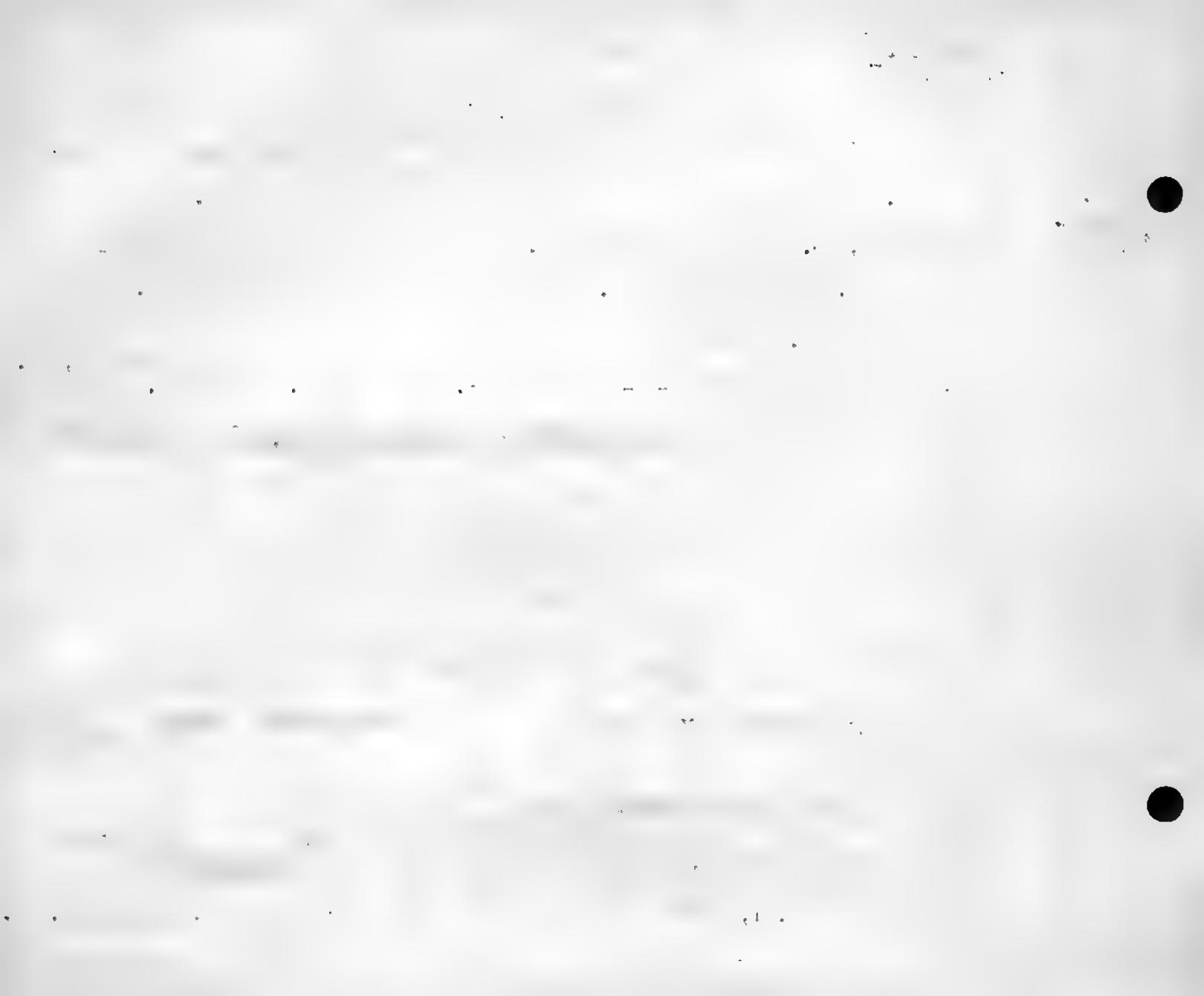
FOR STATE
HEALTH DEPT.PM3 Page
1 of 192with Form
1
1 of 192Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal.

1 of 192 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10282

1 DECEASED NAME (Type or Print)	First L	Middle MARGUERITE	Lost STAIK	2a DATE KNOWN OF ESTI- DEATH MATED	Month 8/27	Day 1968	Year P. M.	2b HOUR
3 SEX Female	4 RACE White	S. DATE OF BIRTH 11/6/1920	6 AGE (in years last birthday) 47 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 8 28		
7a BIRTHPLACE (State or foreign country) Pa.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH Washington Co.			2d HOUR	
10 CITY OR TOWN OF DEATH Hagerstown, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 554 Frederick St.			12a JSJA OCCUPATION (Kind of work done during most of working life, even if retired) School Teacher			12b KIND OF BUSINESS OR INDUSTRY Public School
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b CITY OR TOWN Washington Co. Hagerstown	13d INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 554 Frederick St.		
14. FATHER'S NAME Seba B. Staik		15. MOTHER'S MAIDEN NAME Leila Leiby						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 205-09-9569		17 INFORMANT Seba B. Staik		ADDRESS Chambersburg, Pa.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF <i>Self inflicted gun shot wound of chest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>suicide</i>			
(b) DUE TO, OR AS A CONSEQUENCE OF		(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>976X</i>								
19a. DATE OF OPERATION MATERIAL CERTIFICATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 8/27 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>SUICIDE</i>				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 554 Fred St. (apt)		21f. LOCATION Street or R.F.D. No. Hagerstown		City or Town Hagerstown	County Wash	State MD
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER Howard N. Weeks, M.D.			ASSISTANT MEDICAL EXAMINER		22b DATE SIGNED 8/29/68	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Aug. 31, 1968	23c NAME OF CEMETERY OR CEMETORY LINCOLN CEMETERY			23d LOCATION (City or Town) Chambersburg, Franklin Co., Pa.	(County)	(State)
24 FUNERAL DIRECTOR		ADDRESS HAGERSTOWN, MARYLAND			25a REC'D BY REGISTRAR SFP	25b REGISTRAR'S SIGNATURE Charles Judge		
1 of 100 100								



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12193 CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Forms 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First WILLIAM	Middle STAVROS	Lost	2a. DATE OF DEATH Month AUGUST	Day 11	Year 68	2b. HOUR M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JANUARY 1, 1893	6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 12 HRS HOURS 0	MIN 0		
7a. BIRTHPLACE (State or foreign country) GREECE	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W/DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON						
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AVALON MANOR NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) OWNER				12b. KIND OF BUSINESS OR INDUSTRY BAKERY	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 715 GUILFORD AVE.					
14. FATHER'S NAME GERGE	First STAVROS	Middle STAVROS	15. MOTHER'S MAIDEN NAME EFDIA						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 214-09-2488A	17. INFORMANT MRS. YVONNE STAVROS	715 Address GUILFORD AVE.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1. Duodenal ulcer with recent bleeding.									
19a. MEDICAL CERTIFICATION	19c. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No.	City or Town	County	State				
22a. I certify that (I) (Dr. Charles C. Spencer) attended the deceased from June 8, 1968 , to Aug. 1968 , that (I) (We) last saw the deceased alive on Aug 4, 1968 , and that in (my) (We) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
22b. SIGNATURE Charles C. Spencer	DEGREE CHARLES C SPENCER, M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8/12/68				
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 145 S. PROSPECT, HAGERSTOWN, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/13/68	23c. NAME OF CEMETERY OR CREMATORIAL GREEN LAWN CEMETERY	23d. LOCATION (City or Town) WILLIAMS PORT WASHINGTON MD.	(County)	(State)				
24. FUNERAL DIRECTOR Charles M. Rauze	ADDRESS HAGERSTOWN, MARYLAND	25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 5:30 P.M.	
REBECCA ELLEN		Strasburg		8 19 68		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 8-28-1868		6. AGE (in years last birthday) 99 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Strasburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Foothills-Keedey Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Keeper		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Maryland	13b. COUNTY CARROLL	13c. CITY OR TOWN Union Bridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 101 E		
14. FATHER'S NAME Joseph	First	Middle	Last	15. MOTHER'S MAIDEN NAME Susan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO. 214-54-0368		17. INFORMANT JAMES WARREN FELTZ	Address Union Bridge		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 70 years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION 1/1		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) at work			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 19 1968</u> to <u>Aug 19 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 19 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE G. W. LeVan M.D.		DEGREE ATTENDING PHYS	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED Aug. 19, 1968	
22d. PHYSICIAN'S NAME (Type) G. W. LeVan M.D.		22e. ADDRESS Boonsboro				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE AUG 22 1968	23c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK	23d. LOCATION (City or Town) New Windsor	(County) Rural	(State) MD
24. FUNERAL DIRECTOR D. Hartzer & Sons		ADDRESS Union Bridge		25a. REC'D. BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE Charles J. Jager	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

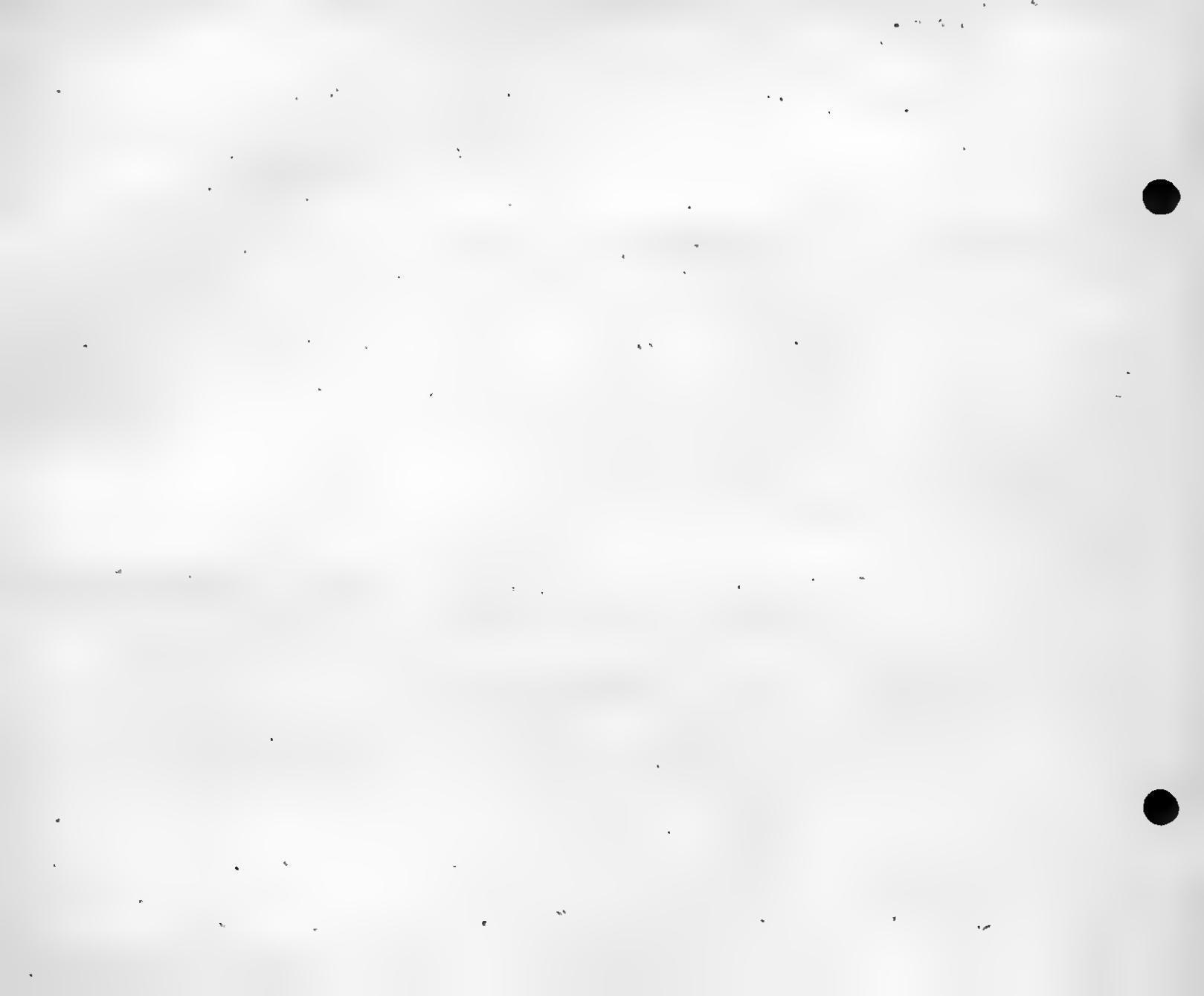
12195

CERTIFICATE OF DEATH

1205

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First CLARA	Middle 	Lost Sullivan	2a. DATE OF DEATH Month August	10 Day 10	68 Year 68	2b. HOUR 9:30 AM		
3. SEX F	4. RACE W	5. DATE OF BIRTH MAY 7, 1894		6. AGE (In years last birthday) 74	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS DAYS 0	9. IF UNDER 24 HRS HOURS 0		
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH WASHINGTON						
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDSTRY None			
13a. USUAL RESIDENCE (Where deceased lived if institution res dence before admission) STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 715 Main St.					
14. FATHER'S NAME First Lillian	Middle 	Lost Akers	15. MOTHER'S MAIDEN NAME First Clara	Middle 	Last Akers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. 	17. INFORMANT Miss Sullivan, Laurel Md	Address 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One week				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5110 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4010 (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Rheumatoid arthritis, Hydroxygo nephrosis, Severe coronary atherosclerosis									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Oct 28, 1967 , to Aug 10, 1968 , that (I) (we) last saw the deceased alive on Aug 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ed. Porciuncula M.D.	DEGREE ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Aug 11, 1968					
22d. PHYSICIAN'S NAME (Type) Ed. Porciuncula	22e. ADDRESS Western Maryland State Hospital								
23a. BURIAL, CREMATION, REMOVAL (Specify) 8 13-68	23b. DATE 8 13-68	23c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cemetery	23d. LOCATION (City or Town) Laurel	(County) Md.	(State) Md.				
24. FUNERAL DIRECTOR Ed. Porciuncula	ADDRESS Laurel Md.	25a. REC'D BY REGISTRAR 	25b. REGISTRAR'S SIGNATURE 						
DATE Aug 21 1968		DATE Aug 21 1968							



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Open please remove carbon paper. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Margaret	Middle Louise	Last Sweeney	2a. DATE OF DEATH 8 Month 8 Day 68 Year 3:30 P.M.	2b. HOUR 3:30 P.M.
3. SEX female	4 RACE white	5. DATE OF BIRTH 5-28-1887		6. AGE (In years 81 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Wash.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) 355 Liberty St.	12a. USUAL OCCUPATION (Kind of work done during day, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 435 Liberty St.	
14. FATHER'S NAME First Jacob	Middle Semler	Last	15. MOTHER'S MAIDEN NAME First Anna	Middle Mead	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO.	17. INFORMANT Robert Sweeney	Address Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line. If (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 41- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs		
(b) + generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Oct 28, 1966, to Aug 2, 1968, that (I) (we) last saw the deceased alive on June 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward W. Ditto	DEGREE ATTENDING PHYS	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 8-9-68	
22d. PHYSICIAN'S NAME (Type) Edward W. Ditto	22e. ADDRESS 212 W. Washington St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-12-68	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Hagerstown Md.	(County)	(State)
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.	ADDRESS	25a. RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles J. Minnich		
DATE AUG 12 1968					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12197

CERTIFICATE OF DEATH

1207

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First CHARLES	Middle RUSSELL	Last TRAIL	2a. DATE OF DEATH Month Day Year AUGUST 21, 1968	2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MARCH 24, 1904		6. AGE (in years at birthday) 64	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HANCOCK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD #1	12b. KIND OF BUSINESS OR INDUSTRY ORCHARDS
14. FATHER'S NAME WILLIAM	First MIDDLE N	Last TRAIL	15. MOTHER'S MAIDEN NAME HELEN	Middle M	Last NORRIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO 212-14-7093		17. INFORMANT AMANDA R. TRAIL RFD #1 HANCOCK, MD.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: +IMMEDIATE CAUSE (a) Coronary Thrombosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 4201					
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary + Cerebral Atherosclerosis 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Thrombotic occlusion of Middle Cerebral Artery					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Aug 16 , 1968, to Aug 21 , 1968, that (I) (we) last saw the deceased alive on Aug 20 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles A. Hoffman	DEGREE ATTENDING PHYS.	22c. DATE SIGNED 8/23/68	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Charles A. Hoffman	22e. ADDRESS 214 N. Pot. St. Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/24/68	23c. NAME OF CEMETERY OR CREMATORIAL PINEY PLAINS METHODIST ALLEGANY CO. MARYLAND	23d. LOCATION (City or Town) LITTLE ORLEANS	(County)	(State)
24. FUNERAL DIRECTOR Richard J. Lyons Hancock, Md.	ADDRESS Richard J. Lyons Hancock, Md.	25a. REC'D BY REGISTRAR Charles J. Jones	25b. REGISTRAR'S SIGNATURE Charles J. Jones	DATE AUG 27 1968	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First DANIEL	Middle F.	Last TROUT	2a. DATE OF DEATH Month Aug. 13, 1968	Year 1968	2b. HOUR 8:30 A.M.				
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 30, 1915		6. AGE (in years lost birthday) 53	7. MONTHS YRS	8. F. UNDER 1 YEAR MONTHS 0	9. F. UNDER 24 HRS DAYS 0	10. HOURS 0	11. MIN. 0	
7a. BIRTHPLACE (State or foreign country) McConnellsburg, Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington						
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash. Co. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mason		12b. KIND OF BUSINESS OR INDUSTRY Const.						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMIT? YES	13e. STREET AND NUMBER 6211 Poe Rd.							
14. FATHER'S NAME First Daniel F. Trout, Sr.	Middle	Last	15. MOTHER'S MAIDEN NAME First May Johnston	Middle	Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WW II	17. INFORMANT 6211 Poe Rd. Mrs. Daniel F. Trout Bethesda, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute Posterior Myocardial Infarction</i> <i>410.9</i> 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>atherosclerotic heart disease</i> many years (b) <i>atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension</i> DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>420.1</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh le <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 10, 1968</i> to <i>Aug. 13, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug. 13, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edson B. Moody</i>		22c. DEGREE <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS	22d. DATE SIGNED Aug. 14, 1968							
22d. PHYSICIAN'S NAME (Type) Edson B. Moody		22e. ADDRESS Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/16/68	23c. NAME OF CEMETERY OR CREMATORIAL Union			23d. LOCATION (City or Town) (County) (State) McConnellsburg, Pa.					
24. FUNERAL DIRECTOR <i>Mr. Loring</i>	ADDRESS Mercersburg, Pa.			25a. REC'D BY REGISTRAR DATE AUG 19 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

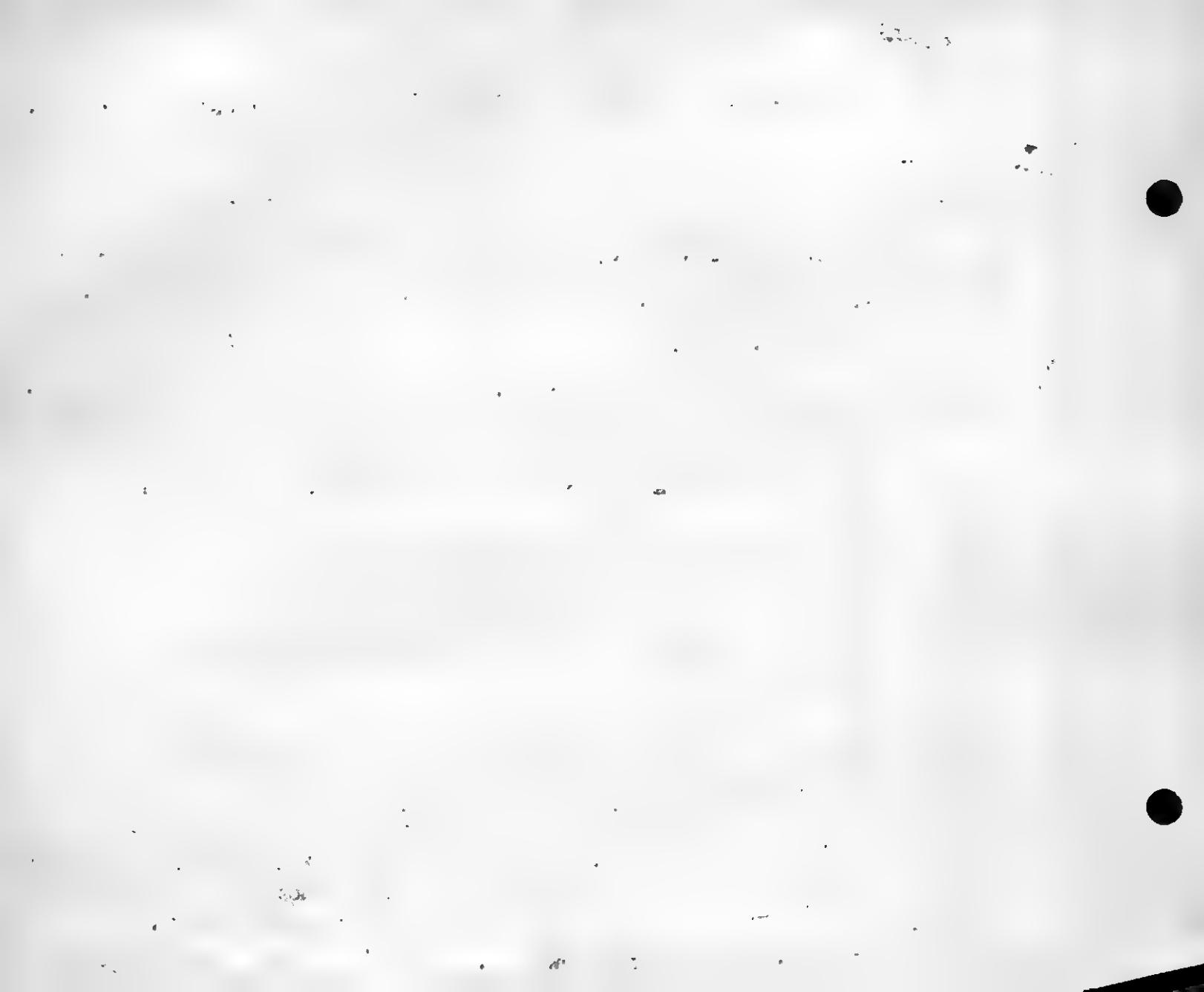
CERTIFICATE OF DEATH

1009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Catharine	Middle Pearl	Last Trovinger	2a. DATE OF DEATH Month August	Day 5, 1968	2b. HOUR 6:20 P.M.
3. SEX female	4 RACE white	5. DATE OF BIRTH 4-7-1904		6. AGE (In years last birthday) 64	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk	12b. KIND OF BUSINESS OR INDUSTRY Dept. Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11 W. Magnolia, Ave.		
14. FATHER'S NAME First William R. Itneyer	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Laura V. Neff	Middle 	Last 	Address
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-09-6503	17. INFORMANT Mr. Donald Trovinger, Dobbs Ferry, N.Y.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>iliac artery.</u>				DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> Years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION 1450		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>21-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/4/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Howard N. Weeks</u>		DEGREE 	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 8/6/68
22d. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22e. ADDRESS 580 Northern Ave., Hagerstown Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-8-68	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	23d. LOCATION (City or Town) Hagerstown, Md.	(County) (State)	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D. BY REGISTRAR DATE AUG 8 1968	25b. REGISTRAR'S SIGNATURE <u>Charles J. George</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

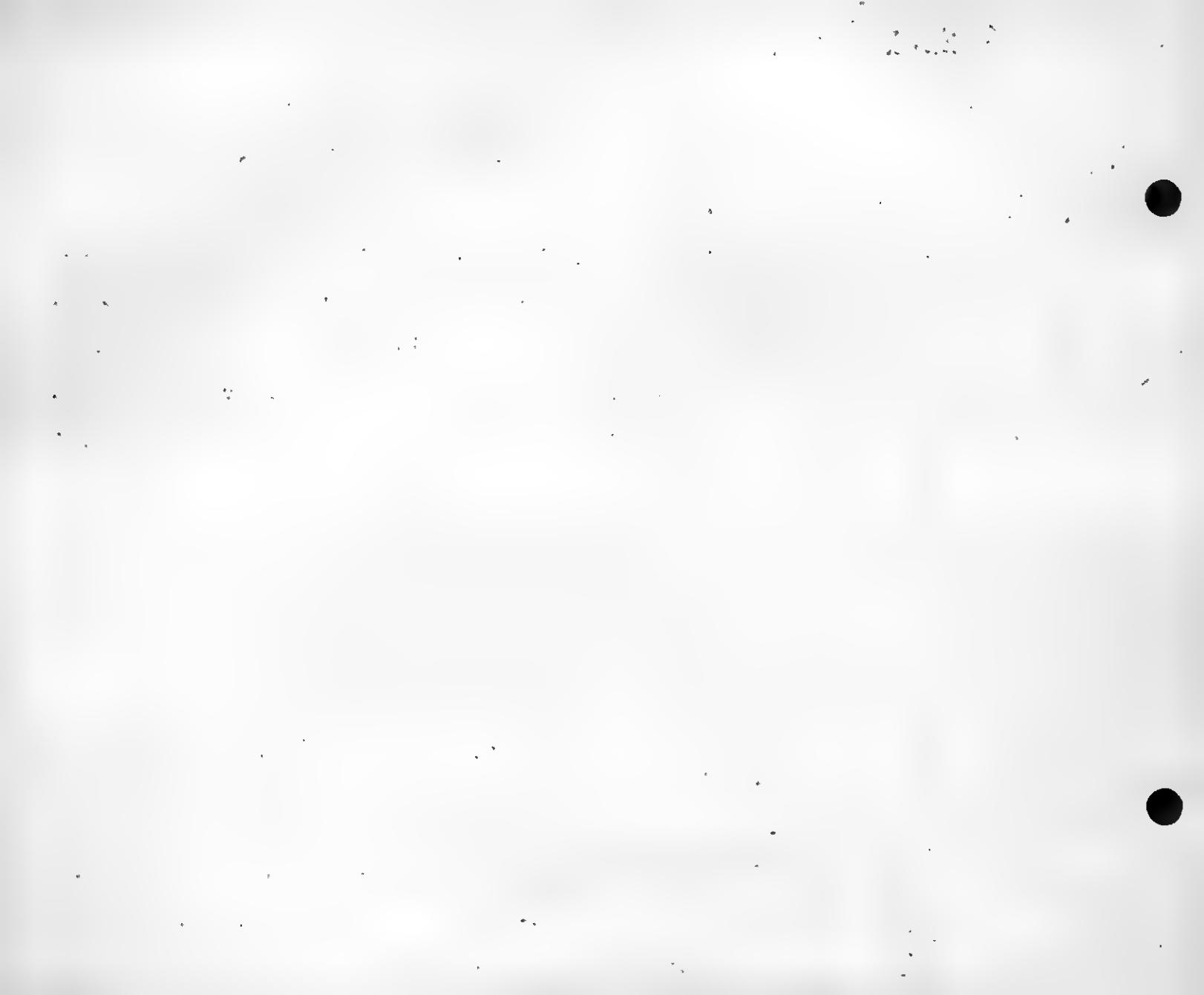
12200

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)	First NORA	Middle CAROLINE	Last TULLIS	2a. DATE OF DEATH AUGUST 30	2b. HOUR 5:50 a.m.
SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JANUARY 16, 1882		6. AGE (In years last birthday) 86	F. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH WASHINGTON	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital g.v. street address) WASHINGTON COUNTY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY, JN. TSP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 450 E NORTH PROSPECT ST.	
14. FATHER'S NAME HARRY	First S	Middle BLOOM	Last	15. MOTHER'S MAIDEN NAME NANNIE	Middle E
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 220-44-6495	17. INFORMANT N.M. TULLIS, 302 CENTRAL AVE., GLYNDON MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hr. 15 min
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not wh <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (Mr. Kneisley) attended the deceased from Aug. 29, 1968, to Aug. 30, 1968, that (I) (We) last saw the deceased alive on Aug. 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
22b. SIGNATURE <u>B.B. Kneisley</u>			DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. DATE SIGNED 8/30/68					
22d. PHYSICIAN'S NAME (Type) B.B. KNEISLEY, M.D.	22e. ADDRESS 148 W WASHINGTON ST., HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9/1/68	23c. NAME OF CEMETERY OR CREMATORIUM REST HAVEN CEMETERY		23d. LOCATION (City or Town) HAGERSTOWN	(County) (State) WASHINGTON MD.
24. FUNERAL DIRECTOR <u>Charles E. Lang</u>	ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR SEP 9 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First			Middle			Last		
Grace			Matilda			Watts			20. DATE KNOWN OF ESTI- DEATH MATED		
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (in years at birthday)	7 F UNDER MONTHS	8 F UNDER 24 HRS DAYS	9 HOURS	10 MIN	Month	Day	Year	
Female	Colored	9-20-1834	83	YRS				Aug	19	1968	
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH		
Clear Spring USA						WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Washington		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Hagerstown Md.			617 Pennsylvania Ave.			Evangelist					
13a U.S.A. RESIDENCE (Where deceased lived, if admission, state)			13b CITY OR TOWN			13c INSIDE CITY LIMITS?			13e STREET AND NUMBER		
Maryland			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 617 Pennsylvania Ave		
14. FATHER'S NAME			First			15. MOTHER'S MAIDEN NAME			Middle		
Josiah			Watts			Unknown			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			ADDRESS		
No			165-07-2343			Miss Anna Watts 617 Pennsylvania Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Massive Pulmonary Hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
L/ Instant											
DUE TO OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) <u>(Possibly Ruptured Aortic Aneurysm)</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
X			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
19c. MEDICAL CERTIFICATION									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		
									County		
									State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Dr. E. W. Ditte, Jr.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
						MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Aug. 20, 1968		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town) (County) (State)		
Burial			8-23-1968			Rose Hill Cemetery			Hagerstown Wash Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REGD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John R. Watson Jr. Hagerstown Md.						AUG 22 1968			Judge		
VR A15ME (5) 10M REV 1/68											



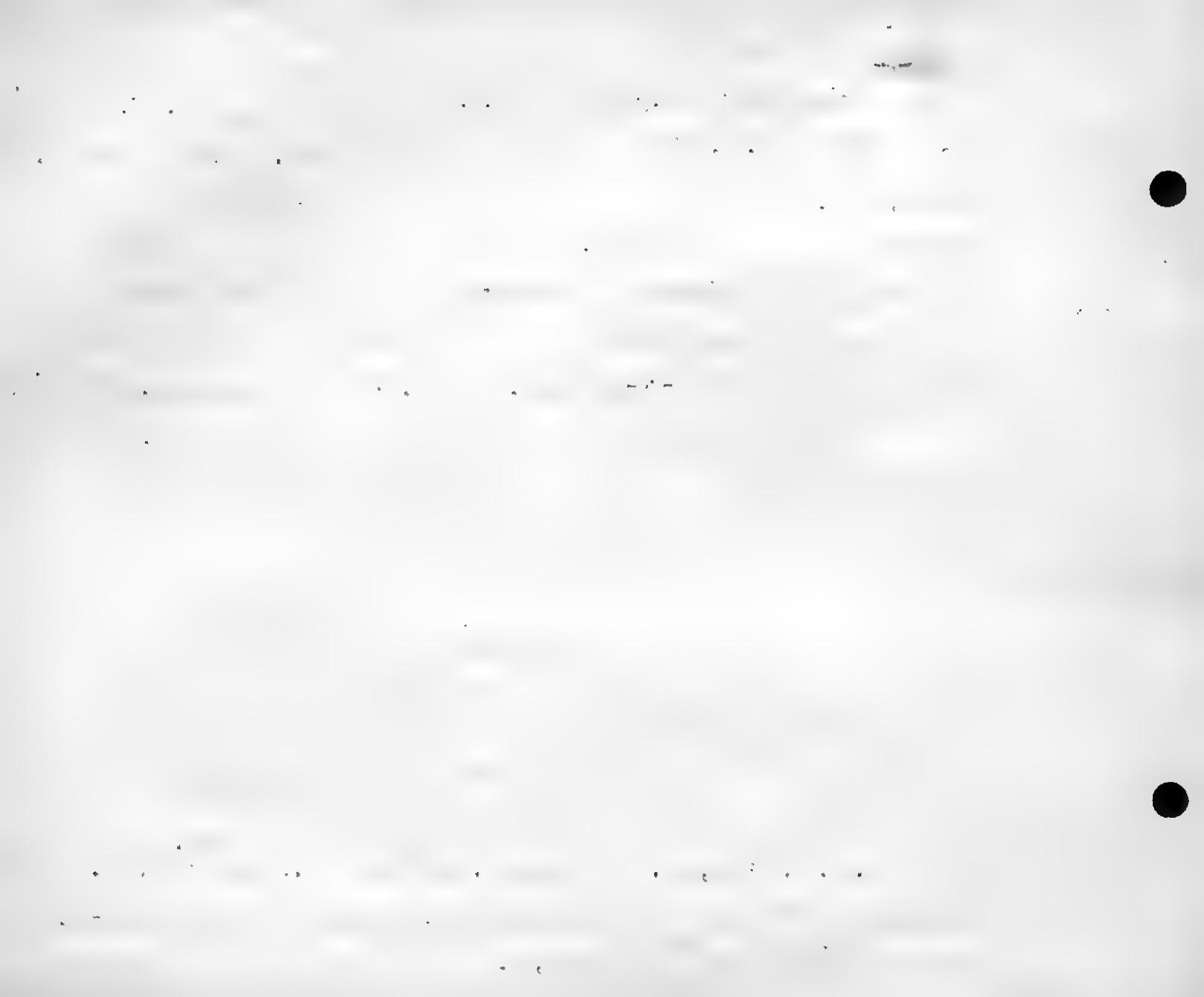
FOR STATE
HEALTH DEPT.Items 21&22a Film 404 MARYLAND STATE DEPARTMENT OF HEALTH Item 22a Film 406
9-3-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
10-14-68 ams

15202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b HOUR M
John Franklin Bernard Wolf				Aug. 22, 68				6:00 P.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH Feb. 12, 1918	6 AGE (In years last birthday) 50 YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN	7c DATE PRONOUNCED DEAD Month Aug 22, 1968 Year P.M.
7a BIRTHPLACE (State or foreign country) Richland, Penna.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/>	EVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Washington
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital D.O.A		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman				12b. KIND OF BUSINESS OR INDUSTRY Insurance-Auto
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY AND TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1017 Columbia Road		
14 FATHER'S NAME Harry	Middle Edwin	Last Wolf	15. MOTHER'S MAIDEN NAME Helen	First Lucile	Middle Yiesley	Last Md.	ADDRESS	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b SOCIAL SECURITY NO WV 11	16c INFORMANT Mrs. Glenna E. Wolf	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning 9109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 6 PM Aug 22 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Drowning				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. Big Poole, Rural Wash. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>								
ACTUAL SIGNATURE <i>A. W. Ditte Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.						
EXAMINER'S NAME (Type) Dr. E. W. Ditte, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, town or county) 215 W. Washington St., Hagerstown, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 8/26/68		23c NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d LOCATION (City or Town) Hagerstown-Washington Md.		
24 FUNERAL DIRECTOR W. G. Horst		ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 29 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	



15203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film Quo 1213

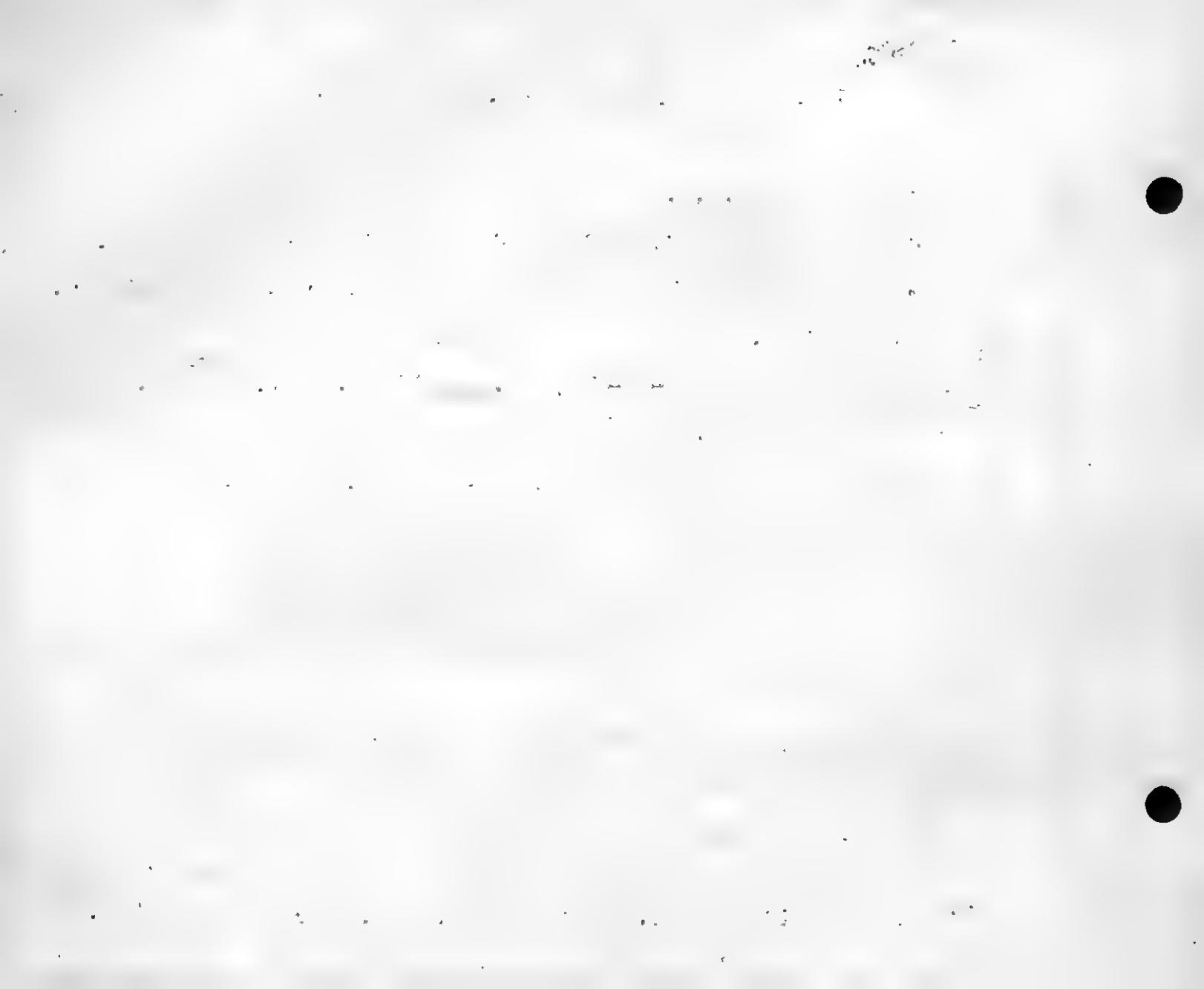
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First CLAUDE	Middle CHESTER	Last WOLFE	2a. DATE OF DEATH Month 18 Day 1968	2b. HOUR 1:40
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH 10/26/68 1894		6. AGE (In years last birthday) 75 YRS.	IF UNDER MONTHS IF UNDER 24 HRS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AVALONMANOR HOME		12a. USUAL OCCUPATION (Kind of work done during working hours) RETired MESsenger		12b. KIND OF BUSINESS OR INDUSTRY BANK
13a. USUAL RESIDENCE (Where deceased admission) ST MARYLAND	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 28 W. LONGMEADOW RD.		
14. FATHER'S NAME First WILLIAM	Middle H.	Last WOLFE	15. MOTHER'S MAIDEN NAME First LIZZIE	Middle GARBER	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (printname) NO	16b. SOCIAL SECURITY NO 212-414-7337	17. INFORMANT MR. CHESTER B. WOLFE	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cervical DUE TO, OR AS A CONSEQUENCE OF (b) Cervical of Prostate gland DUE TO, OR AS A CONSEQUENCE OF (c) 6 mo. BETWEEN ONSET AND DEATH 6 mo.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from JUNE 21, 1968 , to Aug. 18, 1968 , that (I) (we) last saw the deceased alive on Aug. 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lloyd A. Hoffm	DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED 8/19/68	
22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffm	22e. ADDRESS 214 N. Potomac St. Hagerstown, MD.				
23a. BURIAL, CREMATION, BURI (Type)	23b. DATE 8/20/68	23c. NAME OF CEMETERY OR CREMATORIAL LONGMEADOW CHURCH CEM.	23d. LOCATION (City or Town) HAGERSTOWN WASH. MD.	(County)	(State)
24. FUNERAL DIRECTOR W. J. Mortment Hagerstown, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE AUG 22 1968	25b. REGISTRAR'S SIGNATURE Charles J. J. J.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, should be filed with the State Dept. of Health.

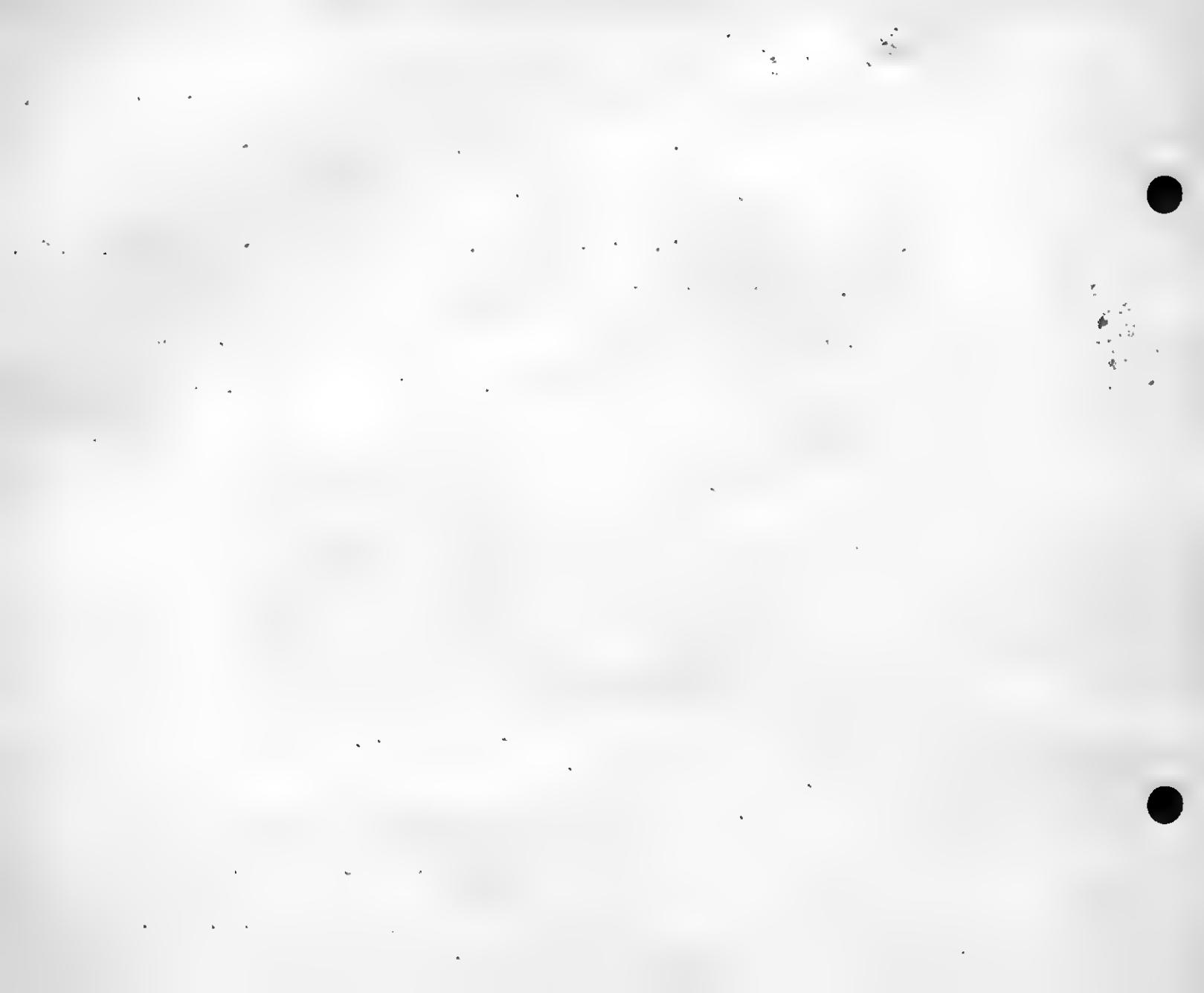


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician or funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please retain this certificate, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR Hour AM	
Henry Christian Leggard Wolffsen					August 17, 1968	7:30 AM	
3 SEX male		4. RACE white		5. DATE OF BIRTH JAN. 1, 1897	6. AGE (In years last birthday) 71 YRS.	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Denmark		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2 N. Wilson Blvd.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Organ mfg.	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b CITY OR TOWN Washington		13c CITY OR TOWN Maugansville	13d INSIDE CITY LIMITS <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME Caspar Wolffsen		15. MOTHER'S M AIDEN NAME Anine Catherine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-09-8610		17. INFORMANT Mrs. Lillian Spielman, Maugansville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Arteriosclerotic Heart Disease				Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>August 28, 1968</u> to <u>Aug 17, 1968</u> , that (I) (we) last saw the deceased alive at <u>Aug 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles C. Spencer, MD</u>		22c. DEGREE MD	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 8/17/68	
22d. PHYSICIAN'S NAME (Type) <u>Charles C. Spencer</u>		22e. ADDRESS 145 S. Prospect St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 8-19-68	23c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		23d. LOCATION (City or Town) Hagerstown, Md.	(County)	(State)
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		ADDRESS Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 20 1968	25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>		



FOR STATE
HEALTH DEPT.



1
16
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form P.M. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12215

12205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First Joseph	Middle Randall	Lost Yeagle	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	Month 8-18-68	Day Year 1968	2b. HOUR A.M.
3. SEX male	4. RACE white	5. DATE OF BIRTH 6-26-1946	6. AGE (in years on birthday) 22 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington	10. DATE PRONOUNCED DEAD August 18, 1968	11. DATE OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Md. #81 & Royer Rd.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Government	12b. KIND OF BUSINESS OR INDUSTRY Marine Corps
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penns.	13c. CITY OR TOWN Bucks	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 711 Old Orchard Lane	14. FATHER'S NAME First Randall F. Yeagle	Middle	15. MOTHER'S MAIDEN NAME First Edna M. Hellings	Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mr. Randall F. Yeagle Bristol, Penna.	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Fourth degree burns on entire body DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8234							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:05 P.M. 8-18 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) auto crashed into private residence			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) MD #81 & Royer Rd.		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ Ft. Ritchie, Washington, Co., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 8-18-68		
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 215 W. Wash. St. ADDRESS (Street, city, town, or county) Hagerstown, Md.		
23a. BURIAL CREMATION REMOVAL (Specify) Removal		23b. DATE 8-19-1968		23c. NAME OF CEMETERY OR CREMATORIAL Bristol, Pennsylvania		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR AUG 20 1968		25b. REC'D BY SIGNATURE J. E. W. Ditto, Jr.	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12206

CERTIFICATE OF DEATH

12216

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	2b. HOUR Year
MARCELINE		MAE	ZOM BRO	AUGUST 9	68 2:30 a.m.
3. SEX	4. RACE		S. DATE OF BIRTH	6. AGE (In years lost birthday) 44 yrs.	
FEMALE	WHITE		MAY 2, 1924	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON	
MARYLAND	U.S.A.				Md.
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 140 W ANTETAM ST.	
14. FATHER'S NAME CECIL	Middle	Lost	15. MOTHER'S MAIDEN NAME HAINES	First	Middle Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 219-20-1087		17. INFORMANT MERLE W ZOM BRO	140 W Address ANTETAM ST. HAGERSTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 174X (b) <u>METASTATIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PRIMARY CARCINOMA OF BREAST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X					
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 11/26, 19 65, to 8/9, 19 68, that (I) (we) last saw the deceased alive on 8/9, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Donald E. Martin, M.D.</i>	22c. DEGREE M.D. ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED 8/9/68	
22d. PHYSICIAN'S NAME (Type) DONALD E. MARTIN, M.D.	22e. ADDRESS 363 S CLEVELAND, HAGERSTOWN, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/12/68	23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY	23d. LOCATION (City or Town) HAGERSTOWN, WASHINGTON	(County)	(State)
24. FUNERAL DIRECTOR <i>Charles E. Ringer</i>	ADDRESS HAGERSTOWN, MARYLAND	25a. REC'D. BY REGISTRAR AUG 12 1968 b. REGISTRAR'S SIGNATURE			
		DATE			

